

**MIDWIVES' VIEWS ON DELIVERY METHOD DECISION MAKING IN PRIVATE
SECTOR LABOUR WARDS OF NAMIBIA**

By

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DECLARATION

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ABSTRACT

Background: The views of midwives regarding decision making in the Namibian private sector hospital labour wards are investigated in this study. The high prevalence of caesarean sections in the Namibian private sector has been the motivation to attempt to understand this phenomenon. Midwives are an integral part in the care of women as prioritised patients, before, during and after childbirth. The objectives of the study included the midwives' views on how women in the labour wards decide on a birthing method, whether the Robson classification for doing caesarean section was being applied in their workplaces, and what their perceived role as advocates entails during the women's decision making of her birthing mode.

Methods: The study used a qualitative design with an exploratory approach. Purposive sampling was applied in the selection of research participants. Permission was granted by the Health Research Ethics Committee of Stellenbosch University and the management of the two hospitals selected for the study. Seven individual interviews for allowing the phenomenon to be explored in-depth were conducted in two private hospitals in Windhoek. Data analysis was done using the six steps by Creswell.

Results: The seven midwives who participated in this study reported that the decisions in the labour wards are affected by a myriad of factors. These include the relationship the midwife has with the doctor, the patient and the institution; trust among and between health professionals, and the availability of adequate antenatal information for the women to make informed decisions about the mode of birth. The following themes and subthemes (in brackets) emerged from the study: midwife (dependent, interdependent and independent role functions); doctor (dependent, interdependent and independent role functions; instrumental and expressive roles; motivations for caesarean sections); patient (antenatal care and expectations of pain management in labour; presence of support or birthing partner); and hospital (policies and guidelines; Robson classification). The study found that women are not well informed about the choices they have for childbirth, about the advantages and disadvantages of the chosen mode of delivery, as well as what to expect during the active stages of labour. The notion that some decisions are influenced by convenience also emerged in this study. Midwives' roles in the Namibian private sector context were found to include decreased independent and increased interdependent functions due to the enlarged role of the private doctor as the primary care-giver, as well as expectations of the institution and the doctor.

Conclusion: Decision making in the labour wards is important, as it determines the birthing method outcome for every woman in the labour ward. Health information during antenatal care needs to be improved to empower women with knowledge, for them to make informed decisions regarding the mode of delivery. The views of midwives emphasised the advocacy role on the part of the midwife, who needs to be more assertive in this role to benefit women in labour. Further studies need to be done in the same context and public hospital settings, to compare the views of women on decision making in the labour wards.

Key words: Midwife role, private sector, decision-making in labour ward, birth plans, caesarean section

OPSOMMING

Agtergrond: Hierdie studie ondersoek die opinies van vroedvroue aangaande besluitneming in die kraamsale van Nambiese privaatsektor hospitale. Die motivering om hierdie verskynsel te probeer verstaan is na gelang van die hoë voorkoms van keisersnitte. Vroedvroue vorm 'n integrale deel van die sorg van vroue wat geprioritiseer word as pasiënte voor, gedurende en na geboorte.

Die doelwitte van die studie was om vas te stel wat vroedvroue se opinies is oor hoe vroue in die kraamsale besluit op 'n geboortemethode; of die Robson klassifikasie vir keisersnit-ooreweging toegepas word in hulle werksplekke; en wat hul waargenome rol is as advokaat vir vroue gedurende die geboortemethode besluitnemingsproses.

Metodes: 'n Kwalitatiewe ontwerp met 'n verkennende benadering is gebruik in die studie. Deelnemers is geselekteer deur middel van doelgerigte steekproefneming. Die Universiteit van Stellenbosch se Etiese Komitee vir Gesondheidsnavorsing en bestuur van die twee privaat hospitale het toestemming vir die studie verleen. Individuele onderhoude was gevoer in twee privaat hospitale in Windhoek (Hospitaal A en Hospitaal B) om sodoende die verskynsel in diepte te ondersoek. Sewe individuele onderhoude was gevoer in twee privaat hospitale in Windhoek (Hospitaal A en Hospitaal B) om sodoende die verskynsel in diepte te ondersoek. Creswell se ses stappe is gebruik vir die data analise.

Resultate: Die sewe vroedvroue wat deelgeneem het aan die studie het rapporteer dat daar verskeie faktore is wat besluitneming in 'n kraamsaal beïnvloed. Dit sluit in die verhouding wat die vroedvrou het met die dokter, die pasiënt en die hospitaal; vertroue tussen gesondheidsorgwerkers; die beskikbaarheid van voldoende voorgeboorte inligting aan die vroue om sodoende ingeligte besluite te maak rakende geboortemodes. Die volgende tema's en sub-tema's (in hakies) het uit die studie na vore gekom: vroedvrou (afhanklike, interafhanklike en onafhanklike rolfunksies); geneesheer (afhanklike, interafhanklike en onafhanklike rolfunksies; instrumentele en ekspressiewe rolle; motiverings vir keisersnit); pasiënt (voorgeboortesorg en verwagtinge rakende pynbeheer tydens geboorte; huidige ondersteuning of geboortevennoot); en hospitaal (beleide en riglyne; Robson klassifikasie). Die studie het bevind dat vroue nie voldoende ingelig is oor die beskikbare keuses wat hulle het ten opsigte van geboorte, asook die voordele en nadele van die gekose geboortemethode, en wat om

te verwag tydens die aktiewe fase van geboorte nie. Dit het ook tydens die studie na vore gekom dat gerieflikheid sommige besluite beïnvloed. Daar is bevind dat vroedvrourolle in die Namibiese privaatsektorkonteks verminderde onafhanklike en vergrote interafhanklike funksionering behels as gevolg van die vergrote rol van die privaat geneesheer as primere gesondheidsorgverskaffer, sowel as die verwagtinge van die instelling en die geneesheer.

Afsluiting: Besluitneming in die kraamsaal is belangrik omdat dit die geboorte metode en uitkoms van elke vrou in die kraamsaal bepaal. Voorgeboorte gesondheidsvoorligting moet verbeter word om sodoende elke vrou te bemagtig met die nodige kennis om ingeligte besluite rondom geboorte metodes te maak. Die sieninge van vroedvroue beklemtoon hul rol as advokate wat meer assertief moet wees om vroue in kraam te bevoordeel. Verdere studies moet gedoen word in dieselfde en publieke hospitaal omgewings om sodoende die sieninge van vroue rakende besluitneming in kraamsale te ondersoek.

Sleutelwoorde: vroedvrou rol, privaatsektor, besluitneming in kraamsaal, geboorte planne, keisersnit

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ABBREVIATIONS

ANC	Antenatal care
CIMS	Coalition for improving maternity services
CPD	Cephalo-pelvic disproportion
HREC	Health Research Ethics Committee
FIGO	International Federation of Gynaecology and Obstetrics
IOL	Induction of labour
MoHSS	Ministry of Health and Social Services
NAMAF	Namibian Medical Aid Fund
NBC	Namibia Broadcasting Cooperation
PET	Pre-eclampsia Toxaemia
SOP	Standard Operating Procedures
SU	Stellenbosch University
VBAC	Vaginal birth after caesarean section
WHO	World Health Organisation

CHAPTER ONE

FOUNDATION OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Pregnancy and childbirth are normal and healthy events that most women, couples, and families aspire to at some point in their lives. However, this normal and life-affirming process might carry serious life-threatening risks of death and disability (National Statistics Agency, 2011:100). Every woman has the right to a positive birth experience, with the need for compassionate and individualised care from skilled and knowledgeable healthcare providers (International Federation of Gynaecology and Obstetrics (FIGO), 2014:95). The International Confederation of Midwives (ICM) (2017:1), states that every woman should have the access to care of a high standard from midwives before and during pregnancy, actual childbirth and postnatal periods regardless of their socio economic status. Furthermore, health care providers have a duty to ensure that women receive the appropriate information so that they can make informed decisions about the mode of delivery.

According to the Robson classification (Vogel, Betran, Vindevoghel, Souza, Torloni et al., 2015:260), all deliveries are classified into one of ten groups based on five parameters: gestational age, obstetric history, foetal lie, number of neonates and onset of labour. Medical staff are advised to use this system to determine the mode of delivery, to ensure that the mother and infant will have a safe delivery.

Developments in technology and advanced medical care have increased the prevalence of caesarean sections, a procedure that has been, and continues to be a critical intervention to save the lives of both mother and baby (World Health Organisation (WHO), 2015:1, Coalition for Improving Maternity Services (CIMS), 2010:1). However, some hospitals are especially prone to unusually high rates of caesarean sections, and the private sector in Namibia is quoted as one such area (Tjihenuna, 2015:5). Yet benefits to mother and baby can be gained from preventing unnecessary caesarean sections to low risk women (Childbirth Connection, 2014:14), also thus decreasing subsequent deliveries by caesarean sections for the same women.

Compared to the WHO ideal proportion of 10-15% or less caesarean sections (Appropriate Technology for birth, 1985:436), the Namibian private sector caesarean section rates reflected

an average of 73% (Namibia Association of Medical Aid Funds (NAMAf), 2015) in 2012, with an upward trend towards 74% in 2014. This contrasts with the public sector where the Ministry of Health and Social Services (MoHSS) takes pride in the fact that 88% of women deliver their babies normally, with only a 12% receiving caesarean sections, thus abiding to the WHO recommended levels of 10 to 15% (MoHSS, 2013). The unavailability and or an overdependence on caesarean section deliveries reflects poorly on the state of healthcare in any country, indicating either that women do not have access to this procedure when necessary, or that they have it electively, without any medical reason, thus increasing the overall financial burden of healthcare (Gibbons, Jose, Belizan, Lauer, Betran et al. 2010:3).

Namibia's health care system has the two pillars consisting of the public and the private health care sectors, and there is no national health insurance scheme. The private sector works in partnership with medical aid societies, as the medical aid societies pay the private hospitals for the services rendered to patients that subscribe with them. The Government of Namibia pays for the services rendered to patients (not completely free as there is a small amount that they pay for obtaining a card for instance) who do not have medical aid and they are treated in the public sector's state hospitals (Brockmeyer, 2012:2).

In the Namibian context, pregnant women in the private sector have private medical doctors as the primary care givers for the antenatal visits, as opposed to the public sector where women have midwives as the primary carers for low risk pregnancies. The midwives in the private sector hospitals have little to no contact with women in the antenatal period as the women go to their doctors for the antenatal visits. A few such private doctors refer patients to the small number of private midwives who offer antenatal classes, but this is essentially for these classes only, and not for the routine antenatal healthcare.

Doula care, a service rendered by a specially trained category of health workers, is based on social support during the labour period, including offering information, emotional assistance and physical support on a one-to-one basis (CIMS, 2014:3). Midwives traditionally used to fulfil this role, with time available for individualised care in the labour ward. In Namibia, Doula care, according to the researcher's observation in the clinical setting, has not yet been established, as it is usually the partner or any other family member who offers support to the woman in labour. Thus, not many pregnant women have exposure to private midwives or doulas offering antenatal classes, as these practices are still not established in Namibia.

For the private sector to be financially viable and show profits to the shareholders, budgets need to be controlled and minimum safe staffing levels applied. Thus, increased workloads and staff shortages are prevalent, and the midwife in the private sector must take care of more than one woman in the 1st and 2nd stages of labour. The doctor expects the midwife to summon him/her only when the baby's birth is imminent, to deliver the infant him/herself, as he/she bills the patient for the delivery. As such, midwives in the private sector are thus stripped from their traditional one-to-one accompanying role. This lack of input of the midwife from the antenatal period to the birth process can influence the choice a birthing mode of delivery, and ultimately this may increase the caesarean section rates.

Health care is an interdisciplinary profession, and in maternity care it is imperative to have good communication between the obstetrician and the midwife, for them to work together towards some individualised care of the woman. Midwives should also have a visible place in the community where Namibian women can choose to access them as the primary caregivers in low risk pregnancies (Kennedy, Beasley, Bradley & Moore, 2010:22) or to offer antenatal care and support to pregnant women. Midwives are governed in their scope of practice by the Nursing Act 8 of 2008, to provide "...effective advocacy to enable the mother and child to obtain the health care they need..." (Republic of Namibia, 2004).

Current insights into the professional roles and role functions for midwives is necessary, to understand their position in the delivery of inter-disciplinary health care in the context of the Namibian private health care sector. They are important health care providers and advocates for woman and fetuses/neonates perinatally, and they can shed light on how decisions are made about the method of delivery in the active labour phase. This is especially important to understand in the context of a predetermined birth plan, as often decisions which do not adhere to such a plan is an outcome in favour of caesarean sections.

1.2 SIGNIFICANCE OF THE PROBLEM

Although caesarean sections are effective interventions where medical complications in pregnancy arise, relating to the mother or the foetus (WHO, 2015:1), the procedure remains a major operation with serious risk factors for the woman as well as the infant (CIMS, 2010:1). However, the choice of a birthing method remains the autonomous decision of the individual woman (Shahoei, Rezaei, Ranaei, Khosravy & Zaheri, 2013:302). Private doctors, as customers of private hospitals in Namibia (Tjihenuna, 2015:5), make use of these facilities to deliver their pregnant patients. As a result, in most cases the birthing method is selected

primarily by the patient on advice from the doctor, simply because of their relationship which dates back to their antenatal visits.

However, midwives are the major care-givers of women in labour, that is, in the active stage of labour in the private institutions, and exploring the midwives' opinions about what happens in the labour ward sheds light on decisions in favour of a caesarean section and divergence from the original birth plan expressed on admission.

1.3 RATIONALE

Too many caesarean sections seem to be the result of women not having enough information to make adequate choices in the birthing process. Midwives are the primary caregivers in the labour wards of the private sector in Namibia, although they are involved to a lesser extent in decision making regarding the choice of birth. As a third party in the relationship between the doctor and the woman in labour, the midwife can attest to the many factors that contribute to the decision-making process. The midwife can help answer how, why and when deviations from the initially set birth plan occur, judging from what transpires from the initiation of the first stage to the conclusion of the third stage of labour.

Thus, the actual decision-making process in the labour wards of private hospitals as observed by the midwife is sought to be understood in this study, to shed light on how decisions regarding the choice for birthing are made. The researcher who is a midwife undertook the study to understand the phenomenon.

Furthermore, the extent to which caesarean sections are accurately classified according to the Robson classification currently may not be applicable for implementation. A retrospective investigation of the Robson classification in determining whether a caesarean section was indicated or not, can help to illuminate and address the problem high caesarean section rates in the future, particularly in the Namibian private health sector.

1.4 RESEARCH PROBLEM

Namibia's high rate of 75% (NMAF, 2015) caesarean sections in the private sector, which is causing increasing concern amongst the public, politicians and the government, necessitated this research. Cronie, Rijnders and Buitendijk (2012:470) argue that women are often pressurised into deciding on a convenient birthing option. This happens at a time when the women is very vulnerable due to pain and extreme discomfort, not having had enough advice

and information about the birthing process, not having enough medical knowledge, and fearing for her unborn infant and her own life. The midwife, as a third party in the labour ward (where options on alternatives about birthing methods are communicated) can therefore give valuable insights about how these decisions are facilitated. Furthermore, the midwife is an advocate for the patient and the unborn infant, and the midwife has a role to investigate anything that might compromise the two patients in this situation.

However, there is a paucity of scientific knowledge about the decision-making process in the active labour phase where birthing options can be (re)considered. There is a gap in the views of midwives pertaining to decisions of mode of delivery and this study sought to understand the views of midwives in order for the gap to be identified.

1.5 RESEARCH AIM

The aim of this study was to explore the views of midwives regarding decision making about delivery methods in the Namibian private sector labour wards.

1.6 RESEARCH OBJECTIVES

RO1 To determine women's decision making on birthing methods in labour wards

RO2 To understand the use of the Robson classification for caesarean sections in the private sector labour wards

RO3 To determine the role of midwives as advocates during the women's decision making on mode of delivery

1.7 RESEARCH METHODOLOGY

A brief description of the research methodology is provided in this chapter as follows:

1.7.1 Research design

The study used a qualitative explorative research design. Exploratory research is designed to increase knowledge in a field of study (Grove, Burns & Gray, 2013:370) when the subject under study is not well known (Neuman, 2011:42), and when no one has yet explored it. This study was exploratory as it sought to understand the views of Namibian private sector midwives with regards to how women in their care in the labour wards decide on a birthing mode. Qualitative research designs address fundamental aspects of reality, with a desire to know more

about a phenomenon, which then gives rise to a view (Grove et al., 2013:265). It also refers to research done through conducting interviews, with transcriptions as forms of data, as opposed to quantitative research which makes use of impersonal questionnaires and statistical data.

1.7.2 Study setting

The study was conducted at two private hospitals that offer maternity services in Windhoek, which is the capital city of Namibia.

1.7.3 Population and sampling

The population for this study was a total of thirty-five midwives working in the two selected private hospitals' maternity wards. The sample size that was selected to represent the total population was ten midwives, and purposive sampling was used.

1.7.4 Inclusion criteria

The inclusion criterion for the study was that the midwives chosen for the sample had to have been working in the maternity departments of the two selected private hospitals in Windhoek for a minimum period of six months.

1.7.5 Data collection tool

The study was conducted using semi-structured individual interviews with open-ended questions (see Appendix 5). Face-to-face interviews were preferred, as they also gave the researcher the opportunity to probe further, whilst mannerisms were observed and addressed during the interview and hence more useful data were obtained from research participants.

1.7.6 Pilot interview

Two pilot interviews were conducted with midwives from the total population, and this helped towards acknowledging the different interpretations of the Robson classification by the respondents. The researcher then decided to introduce the Robson classification to all research participants for familiarisation before the interviews. The data collected from the pilot interviews were useful, and as such they were included in the research.

1.7.7 Trustworthiness

In quantitative studies, trustworthiness is defined through reliability and validity, which are characterised by the extent to which multiple researchers will have similar results when they do a similar study, using the same procedures. In qualitative research though, researchers are allowed the freedom to describe their research in ways that highlight the overall rigor of qualitative research without trying to force it into the quantitative model (Given, 2008:895).

The study followed the four principles of trustworthiness in qualitative research, namely credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985), to ensure validity, and this is further expanded upon in chapter 3 of the present study.

1.7.8 Data collection

Data was collected in Windhoek, Namibia in the two months of March and April 2017. The interviews were conducted by a field worker at hospital B, whilst the present researcher conducted the interviews at hospital A, and all the interviews were audio recorded.

1.7.9 Data analysis

Data analysis in qualitative studies starts from data collection, and in this study the 6-step data analysis process of Creswell (2009:189) was used. These six steps are namely, the organisation and preparation of data, exploration and codification of data, building of descriptions and themes, representing and reporting findings, interpreting findings, and lastly, validating accuracy of the findings (Creswell, 2014:261).

1.8 ETHICAL CONSIDERATIONS

The research was approved by the Health Research Ethics Committee (HREC) at Stellenbosch University (SU) (see Appendix 1) on the 22nd of August 2016 (S16/05/097). The Namibian Ministry of Health and Social Services approved the study on the 14th of November 2016 (see Appendix 2), and the two participating hospitals gave approval in Windhoek on the 8th and 16th of December 2016 (see Appendix 3). An amended approval by the SU HREC was provided on the 28th of February 2017, to allow the researcher to conduct the interviews herself at one hospital, as per this hospital's requirements, as opposed to having a field worker (see Appendix 7) interviewing the midwives at this specific hospital.

The study incorporated all ethical protocols, inclusive of the Helsinki declaration of 1964 as reviewed in 2013 (World Medical Association, 2017). These protocols spell out the ethical guidelines to be used for medical research, to ensure that it does not harm the participant. De Vos, Strydom, Fouche and Delport (2011:114) state that ethical guidelines provide researchers with a set of moral principles that offer rules and behavioural expectations when conducting the study. Ethical guidelines help to make justified moral decisions and to evaluate the morality of actions (Butts & Rich, 2008:42). Therefore, the researcher was guided throughout the research by this set of ethical guidelines, so as not to violate the rights of the research participants.

1.8.1 Right to self-determination

On first contact, the research participants were informed of the purpose of the study and all information was made available to them through information leaflets. The research participants were informed that they could withdraw at any time in the study. They were given the right to schedule the interviews where and when they saw fit, to their convenience. All participants were asked to sign informed consent forms in English, as this language is used in the hospital settings as it is the official language of Namibia. Participants were also encouraged to give recorded verbal consent at the onset of the interview. Research participants who had any questions were given the opportunity to ask and relevant information was given.

1.8.2 Right to confidentiality and anonymity

The privacy of participants is assured once confidentiality and anonymity and the nature and degree of invasion have been secured (Pera & Van Tonder, 2011:335). Although signed informed consent was obtained, pseudonyms were used with all research participants during interviews, and with data transcription. The signed consent forms were stored away and not referred to again, and they will be kept with the transcriptions under lock and key for at least five years after the study. The computers of all parties involved in carrying out this research are password protected, to avoid giving illegal access to the audio files and the transcriptions of the research project. The researcher will keep the printed transcripts in a safely locked drawer for five years, so that the original scripts can be perused for validity and trustworthiness as and when necessary. The voice recordings were deleted after transcriptions had been done and approved by the supervisor. The participants were assured of confidentiality and anonymity by not verbalising their names during the interviews, and not mentioning the setting they worked at. On the transcriptions and quotes their names were replaced with 'xxx' as indicated in chapter 4 when data was presented.

1.8.3 Right to protection from discomfort and harm

Non maleficence refers to not inflicting harm to the research participant (Pera & Van Tonder, 2011:335). No risks were anticipated in this study. The research participants were offered refreshments during the interview to ensure that little discomfort was experienced, as it took approximately 30 minutes to conduct the interview.

1.9 OPERATIONAL DEFINITIONS

Antenatal - relates to the period of pregnancy before birth (Martin, 2005:34). In this study it means the period from the first visit to a primary care giver during pregnancy, to the actual moment of birth.

Caesarean section - the surgical removal, by abdominal incision, of the products of conception as a viable foetus (Sellers, 2013:754). In this study, caesarean section includes infant deliveries by surgical interventions.

Caesarean section rates - total number of caesarean deliveries over the total of all births in percentage (Sellers, 2013:754). Rates in this study mean the same as the definition provided.

Decision making – in this study the term refers to the outcome of birthing method in the labour wards.

Doctor – means a person registered as such in terms of the Medical and Dental Act of Namibia (Republic of Namibia, 2004) or regarded to be so in terms of section 64 of the Act. In this study a doctor refers to the medical practitioner, be it a general practitioner or a specialist that attends to the woman in the antenatal period and during labour in private hospitals in Namibia.

Institution – refers to a health care facility that facilitates perinatal care.

Midwife – this means a person registered as such in terms of section 64 of the Nursing Act of Namibia (Republic of Namibia, 2004). In this study it means a registered nurse caring for women in the labour wards when they come in to deliver.

Patient – refers to the woman who is pregnant, and in labour in this study.

Perinatal – around the time of birth (Sellers, 2013:9). In this study it includes the time during labour and within the time the baby is born, before discharge.

Post-natal - relates to the period following childbirth (Martin, 2005:506). In the current study it means the immediate period after the woman has given birth until discharge.

Views – refers to what the midwives in the private sector labour wards perceive are the decisions made regarding mode of delivery.

1.10 DURATION OF THE STUDY

Ethical clearance for this study was obtained on the 22nd of August 2016, with an amendment approved and obtained on the 28th of February 2017. The pilot interview took place on the 3rd of March 2017, and the rest of the interviews between the 21st of March and 15th of April 2017. The thesis was finally handed in on 30 November 2017.

1.11 CHAPTER OUTLINE

Chapter 1: Foundation of the study

This chapter provides the background to the problem of increased caesarean sections worldwide, and describes the relevance of the views of midwives regarding decision-making about the mode of delivery, the significance of the study, the research problem, the objectives, the research design, the methodology and the ethical considerations according to the Helsinki declaration.

Chapter 2: Literature review

In this chapter, an in-depth literature review is conducted about the prevalence of caesarean sections and the problems associated with this situation internationally and nationally, as well as the role that midwives play as care givers and facilitators in the labour ward.

Chapter 3: Research methodology

In chapter 3, the qualitative research design and methodology of this study are discussed in detail. The population, sampling, the data collection and analysis methods are described in this chapter.

Chapter 4: Results

The data analysis and the interpretation thereof are presented as themes and subthemes in this chapter

Chapter 5: Discussion, conclusions and recommendations

In chapter 5, the findings of the study are discussed, together with conclusions and recommendations that are based on the scientific evidence obtained in the study.

1.12 SUMMARY

In this chapter the rationale, significance of the study, aim and objectives for this study were introduced. Furthermore, a brief description of the methodology and of the ethical

considerations were provided. Lastly, an outline of the chapters was described and terminology and acronyms defined.

1.13 CONCLUSION

The incidence of caesarean sections has increased greatly over time, without the explanations provided for this phenomenon being questioned. Pregnancy and birth should be the best possible experience for any family and as such it should not compromise future pregnancies/deliveries. Thus, informed decisions about the possible modes of birth need to be done by women and their partners. Since it is possible that women already have birth plans in place on admission, concerns have therefore been raised about how these birth plans are influenced and changed during labour which may contribute to the high caesarean section rates.

The obligations of the World Health Organisation are to ensure that caesarean sections are necessary and lifesaving, through the proper dissemination of information regarding rationales for a proper mode of birth. There are factors at play in the decision-making about birthing methods in the active phase in the labour ward, which the midwives as the birth attendants are privy. Knowledge of these factors can help those outside the labour ward to understand and to affect improved decision-making. With proper information obtained, maternity and obstetric care has the potential to improve and empower pregnant women regarding mode of delivery choices.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter one gave a basic overview of the context of the study. In the current chapter, relevant literature to the phenomenon is reviewed. The review of literature published less than ten years ago helps to identify the trends and choices about delivery methods and midwives' influence on these methods. This helps to understand what is known about the topic, and to identify gaps in knowledge to make this study relevant.

Firstly, definitions of a vaginal delivery and a caesarean section are provided, followed by the reasons why caesarean sections are performed, and how decisions are made to determine the mode of birth in the labour wards. Literature reviews about the views of midwives on the choice of the birthing method in other settings are included in this chapter, as well as obstetricians' views on the delivery method. Moreover, the perspectives of the World Health Organisation regarding caesarean section rates worldwide are also considered.

2.2 VAGINAL DELIVERY

A vaginal delivery refers to a delivery of a fetus, placenta and membranes per vagina that happens naturally on its own, without any intervention from healthcare personnel to help pull the baby out, and this occurs after a pregnant woman goes into labour, which opens her cervix to at least 10 centimeters (Sellers, 2013:140). Assisted vaginal delivery in contrast, is the vaginal delivery with the assistance of instruments like forceps or vacuum (Sellers, 2013:140).

2.3 CAESAREAN SECTION

A caesarean section refers to the birth of a foetus, placenta and membranes through an abdominal and uterine incision (Dechenery, Nathan, Goodwin & Laufer, 2007:469), and it can be either an emergency or an elective procedure. During an emergency, a vaginal birth is impossible or dangerous to the mother or the foetus in the process of labour, and the caesarean section is chosen to prevent damage to either. During an elective caesarean section, the mother would have chosen this mode of birthing in the absence of obstetric or medical contraindications, or it has been decided beforehand by the doctor that due to, for example

having an android (male type) pelvis, the infant would not be able to pass normally through the birth canal (Mylonas & Friese, 2015:490).

2.3.1 Complications, alternatives for caesarean sections and the Robson classification

Caesarean sections are not without relative risks associated with complications, and alternative interventions will be discussed in the following section. The Robson classification will also be discussed in this section.

2.3.1.1 *Maternal complications of caesarean section*

Many organisations that deliver maternal health care identify a lack of quality scientific evidence on the risks associated with elective caesarean sections (Gallagher, Bell, Waddell, Benoit & Cote, 2012:40). As infections are more prone with major surgical interventions such as caesarean sections, Lavender, Hofmeyr, Neilson, Kingdon and Gyte (2012:4) argue that admission in intensive care units due to septicaemia as a surgical risk can increase maternal mortality, and an orphaned new-born as a result. Furthermore, Dechenery et al. (2007:337) provide evidence that caesarean sections have higher complications in future pregnancies such as placenta accreta (a condition where the blood vessels or parts of the placenta attach deeply to the uterine wall, Sellers, 2013:167) and adhesions. A large degree of placenta accreta can result in heavy uterine bleeding post-delivery and the need for an emergency hysterectomy early in a young woman's fertile life.

Post-Partum haemorrhage (PPH) is defined as blood loss of more than 500mls post birthing in the first 24 hours and it can be caused by different factors including trauma to the genital tract, clotting factors, caesarean sections and atonic uterus among others (Sellers, 2013, 135). PPH is one of the leading causes of maternal deaths especially in low income countries and is also rated as the primary cause world over accounting for a quarter of all maternal deaths (WHO, 2012:3).

2.3.1.2 *Neonatal complications of caesarean section*

Complications associated with the baby when a caesarean section is done before 38 completed weeks of pregnancy include problems with respiration, digestion, jaundice, dehydration, infection and regulating blood sugar levels because of prematurity (Childbirth Connection, 2012:7). The higher possibilities of respiratory complications could be severe enough to require admission to a neonatal unit for days and respiratory assistance via ventilators (CIMS, 2010:2).

In addition to the above respiratory problems that can affect the newborn is transient tachypnoea which is a condition which affects the respiratory system when the newborn has fast breathing. Transient tachypnoea has been associated mainly with babies born through caesarean sections especially in patients where labour had not yet begun and born before 38 completed weeks of gestation (Keles, Gebesce, Yazgan, Tonbul & Basturk, 2015:2). Even if a caesarean section is scheduled after 39 completed weeks of pregnancy and above, when the risks are minimised, it still does not eliminate respiratory or other potential complications as a risk. Lastly, there is the real possibility of accidental surgical lacerations or incisions on babies when a caesarean section is done (Childbirth Connection, 2012:22).

2.3.1.3 *Alternatives to curb caesarean sections*

In addition to the above, there are alternatives that could be used to reduce the rates of caesarean sections, including induction of labour (IOL), vaginal birth after caesarean section (VBAC) and antenatal health education. IOL is the deliberate initiation of uterine contractions prior to the spontaneous onset of labour (Sellers, 2013:452). A failed induction is often given as a reason for prolonged labour, and thus for a caesarean section, which ultimately impacts negatively on the caesarean section rates of a country (Banos, Migliorelli, Posadas, Ferreri & Palacio, 2015:165).

However, researchers have questioned the motivation for inductions and reasons for ‘prolonged labour’, as many failed inductions are usually done under 41 weeks of gestational age without any medical reason, and the cervix might not have been favourable then (Childbirth Connection, 2014:1). The cervix becomes favourable as the foetus engages in the pelvis in the last few weeks of pregnancy, and it begins to exert pressure on the cervix. A favourable cervix is measured using the Bishop score, which indicates cervical dilatation, effacement, station of the presenting part, consistency, and position of the cervix on a score of up to ten (two being the highest score and zero the lowest for each of the determinants), predicting if induction of labour will be effective (Sellers, 2013:453). A certain number of inductions will be successful, depending on the Bishop score above eight, but those below this score have the worst chances for a successful vaginal birth.

International guidelines of the WHO provide that inductions must only be done after the woman has failed to go into spontaneous labour after 41 completed weeks of pregnancy (WHO,

2015:4, Childbirth Connection, 2014:2). With such a policy, it has been demonstrated that the caesarean section rates decrease and perinatal outcomes are improved (Banos et al., 2015:164).

Offering VBAC is one way of reducing caesarean sections, the risk of potential complications and surgical costs, and this should be done under the supervision and vigilance of health care personnel as there is a potential risk of complications such as the uterus rupturing (Chong, Su & Biswas, 2012:4). Furthermore, in South Africa, in the Saving Mothers Report, it is proffered that there are protocols to be followed in attempting VBAC, and one of them is the availability of resources and infrastructure to perform caesarean sections (Saving mothers, 2012: 53).

2.3.1.4 The Robson classification and its effects

The WHO's policy (2015:1) demands that efforts should be made to ensure that caesarean sections are provided to women in need, rather than to strive to achieve a specific rate. The Robson classification identifies the categories in which decisions towards most caesarean sections should fall. In this sense, the Robson classification is there to guide and give information, thus decreasing the need for inopportune caesarean sections. The Robson classification groups women who present in the maternity unit in one of ten groups, based on the five characteristics in obstetrics of parity (nulliparous vs multiparity), onset of labour (IOL vs spontaneous or preterm), number of foetuses (single vs multiple), gestational age (preterm vs term) and foetal presentation (breech vs cephalic). This tool is generally and purposively used retrospectively.

With a systematic review conducted in 2011 as background and evidence, the WHO (2015:2) concluded that the Robson classification was the most appropriate system to fulfil current international and local needs in aiding decision-making about the need for a caesarean section. Another systematic review conducted at Assiut University Hospital in Egypt confirmed that the Robson classification could serve as an internationally applicable caesarean delivery classification system (Abdel-Aleem et al., 2013:119). In the above review, the aim of the study was to identify amongst the ten groups those subgroups that contributed the most to the rise of caesarean deliveries, with the result being the group with multiparous women with previous scars (Abdel- Aleem et al., 2013:121).

Moreover, Scandinavian countries did their own systematic reviews to evaluate reasons for the caesarean section rates in their settings using the Robson classification. Before the study, increases in caesarean rates were as follows: Denmark increased from 16.4 to 20.7%, Norway

from 14.4 to 16.5% and Sweden from 15.5 to 17.1%. However, towards the completion of the study, through applying the Robson classification, there was a stabilisation or decrease in the caesarean section rates. The explained initial increase in the caesarean rates was mainly from the group of women who had had previous caesarean sections. In Finland and Iceland however, a decrease from 16.5 to 16.2% and 17.6 to 15.3% respectively in the caesarean section rates resulted when nulliparous women and women with a previous caesarean section scar were given the opportunity to deliver vaginally through the application of the Robson classification (Pyykonen, Gissler, Lokkegaard, Bergholt, Rasmussen et al., 2017:2). These findings are supported by a review in Singapore that showed that for a reduction in caesarean section rates altogether, there must be a reduction in the caesarean sections in nulliparous women, and an encouragement of VBAC (Chong et al., 2012:4).

In Sub-Saharan Africa, a similar study using the Robson classification was done in Ivory Coast. The caesarean section rate which increased from 38.7 to 41.7% in the Cocody Hospital Centre was attributed to an increase in caesarean sections among the nulliparous group of women and those with a previous scar (Loue, Gbary, Koffi, Koffi, Traore, et al., 2016:1773). Moreover, WHO's systematic reviews of the Robson classification in several countries including African countries like Nigeria, Kenya, Uganda and Congo also indicated an increase in the caesarean section rates from 26.4 to 31.2% across all the groups, but mostly in women who had a caesarean section after IOL in multiparous women (Vogel et al., 2015:260).

Although the above are systematic reviews of the use of the Robson classification the WHO urges policy makers to make use of the classification prospectively as it in the same way guides care givers on how to avoid unwarranted caesarean sections in low risk women (WHO, 2015:2). A retrospective analysis of the caesarean cases already done helps caregivers to identify groups in which the caesarean sections were high and how to decrease the incidence of the caesarean sections.

2.3.2 Global overview of caesarean sections

The incidence of caesarean sections has increased globally over the last few decades (Mukherje, 2006:298; Nottle, 1998:494) and it continues to do so. Even in Sweden, where midwives are the primary care givers and less caesarean sections occur, the caesarean section rate has risen from 5.3% in 1973 to 17.1% in 2012 (Johansson, Hildingsson & Fenwick, 2014:209), demonstrating a steady increase over a 40-year period. Canada had a 25.6% rate in

the 2004-2005 period (Chalmers, Kaczorowski, Darling, Heaman, Fell, O'Brien & Lee 2010:44) and the rate currently is at 26.8% (Fariene & Shepherd, 2012:977).

Furthermore, some countries report rates of between 35 - 45% (Chen & Hancock, 2012: 20) and higher (up to 70% and beyond). An Iranian study (Shahoei et al., 2013:303) reported a rise in the caesarean section rate from 19.5% to 35% between 1976 and 2000, with the latest statistics showing that it is currently 42.3% in the public sector, and more than 90% in the private sector.

However, higher caesarian section rates do not necessarily reduce mortality. The WHO (2015:2) reports that caesarean section rates higher than 15% have not resulted in less mothers or infants dying at birth. That said, one must therefore consider whether these increased caesarean section rates indicate higher risk populations.

Governments continue to implement and enforce policies to address the prevalence of caesarean sections. During 1981, the American Department of Health published a comprehensive report on caesarean sections, in which it expressed concern over the high incidences of the procedure in the United States with 17.9 per 100 deliveries (Cronje & Grobler, 2003:333). Twenty years later, in the year 2000, a national goal was set to lower the rate of repeat caesarean sections by 3%, while increasing vaginal birth after caesarean section (VBAC) to 35% (Dechenery et al., 2007:469). In 2013, the caesarean section birth rates were still as high as 32.7% in the United States (Osterman & Martin, 2014:2). However, new national objectives have been set through the 'Healthy People 2020' initiative to reduce caesarean delivery rates by 10 % among low risk populations such as first-time mothers, and those who have had a previous caesarean section (Osterman & Martin, 2014:2). In the same vein, in Brazil, the Ministry of Health imposed an upper limit to the caesarean section rate at 35% in the public sector and 70% in the private sector (Mukherjee 2006:298).

Moreover, the WHO (2015:2) doubts the rationale for caesarean sections and it questions the competencies of health care providers who decide about this issue of concern. Lampman and Phelps (1997:159) have declared that the rise in the rate of caesarean sections reflects the medicalisation of childbirth, thus treating childbirth as an illness or pathological state needing medical intervention, instead of it being a natural occurrence in the lifespan of a woman.

2.3.3 Regional overview of caesarean sections

In Africa, there are different factors contributing to high maternal mortality rates. In Sub-Saharan Africa, barriers to maternal health success include cost, access, infrastructure and an information deficit, to name but a few (Africa Progress Panel, 2010:6). There are cases of women not being able to access quality health care when they need it, with some women with complications that need a caesarean section not having access to the procedure (Africa Progress Panel, 2010:8). In Malawi, a study found that only 13 % of clinics had 24-hour midwifery care, which poses a major obstacle for women facing emergencies and complications, hence their increased mortality rates (Africa Progress Panel, 2010:8).

In most African states, there is also a lack of midwives to attend to the rising number of women who need midwifery care. In a study done in Sub-Saharan Africa, a ratio of 13.8 of nursing and midwifery personnel for every 10 000 women was found, with the most deprived areas having an even worse ratio at less than 1 midwife per 100 000 people, with a crippling effect on the health sector (Africa Progress Panel, 2010:8). Because of women not having midwives to monitor them during labour, an over and underuse of caesarean sections has been observed. Furthermore, Bergstrom and Goodburn (2011:7) mention that Traditional Birth Attendants have been used to help with normal deliveries, resulting in then holding a special place in the community such as in Ghana. However, some Traditional Birth Attendants, unfortunately, still conduct high risk pregnancies which should have been referred and thus they contribute to the high mother and infant mortality rates in Africa.

An audit done at six private hospitals over a three-year period, and reported on in 2002 in South Africa, found an average caesarean section rate of 57% (Naidoo & Moodley, 2009:254). In 2004, Naidoo and Moodley (2009:257) reported a 65% caesarean section rate in South Africa in the private sector, which shows a 7% increase over 2 years. The study also showed that 74.6% of all the caesarean sections done were performed electively, with the most common indication being a previous caesarean section (Naidoo & Moodley, 2009:256).

Furthermore, a WHO report about caesarean section rates mentioned that the national rate of caesarean sections in Namibia was 12.3% and South Africa 20.6% in 2010 (Gibbons et al., 2010:24), and more recent statistics in Namibia indicate that the caesarean section rates currently stand at 14.9% (Mackenzie, 2017:6). These statistics for Namibia show that the public-sector caesarean section rates are within the guidelines of the WHO recommendations and they are regionally comparable to those of South Africa. Yet still there is a situation of

huge variations that exist in Africa, with some facilities having a high percentage of caesarean sections, and on the other hand having others who are deprived of access when there is a critical need (Maswime & Masukume, 2017:5).

2.3.4 Namibian overview of caesarean sections

To contextualise the study further, a brief overview of Namibia is important. Namibia is a vast country with a total population of approximately 2 113 077 inhabitants (National Statistics Agency, 2011:3). Namibia contributes to the high caesarean rates in Africa and globally, as it also bears high rates, mainly in the private sector.

However, the Namibian public has become more aware of these high rates through comparisons with other countries like Brazil, which is attempting to address similar problems (Smith, 2015:26; Tjihenuna, 2015:5). The Namibian Broadcasting Cooperation (NBC) aired television and radio talk shows in 2015 and 2016 with regards to this contentious issue and it has been proposed that the Ministry of Health and Social Services should seriously probe this issue.

NAMAF is the corporate body that deals with medical aid schemes in Namibia, and people with medical aids are those who can afford private hospital care. Ideally, medical aid schemes only fund caesarean sections when clinically motivated; nevertheless, more caesarean sections occur in the private sector than in the public sector which serves those without medical aid coverage (Willie, 2012:84). According to NAMAF, Namibia records a 75% caesarean section rate in the private sector, with a resulting decline in vaginal births (NAMAF, 2015).

Dr Haufiku, as the Minister of Health of Namibia (as of 2017), has verbalized that quality healthcare still remains a pipe dream whilst the abnormal upward trend of caesarean sections (three times more expensive than normal deliveries) continues (Beukes 2015:2). Furthermore, the prevalence of caesarean sections has been recognised in academia as contributing to the inability to adequately finance health care in Namibia. Professor Nyarang'o, in his inaugural lecture at the School of Medicine at the University of Namibia, addressed the discrepancy between the fact that poor women in the country that desperately need caesarean sections are dying due to lack of access to this intervention, whilst in the private sector some pay dearly for the privilege to have an elective caesarean section as a birthing method (Mackenzie, 2017:13, Beukes, 2015:2).

Because medical aid schemes as third parties are paying these bills for caesarean sections, patients are less aware of the cost of the procedure, with the main cost determinants being the doctor, and the hospital that claims money from the medical aid scheme for the procedure. Herrero (in Smith, 2015:3) states that ignorance and the desire for convenience motivates mothers-to-be to choose caesarean sections. On the other hand, it has been argued that doctors and hospitals are motivated by the ability to schedule birth to the minute, with more control over the length of the birthing process, in effect optimizing the amount of deliveries by caesarean sections to improve income. Khazan (2014:2) states that patients feel pressurised to agree to caesarean sections, even when they initially insisted on a natural birth. Therefore, they give in when the pain becomes prolonged and unbearable, instead of having been offered other methods of pain relief, for example Entonox gas or Pethidine injections (an opiate given intramuscularly), or just the continuous presence of a soothing birth attendant.

Magadza (2013:2) professes that health care services at public and private health facilities may appear cheap, but the hidden costs are bleeding the state and the patient financially. Increased caesarean section rates have a bearing on higher health care costs as more staff and equipment are needed for the procedure (Gibbons et al., 2010:8), and this can be a lucrative income generating production line, with anaesthesiologists (epidural and spinal anaesthesia in delivery), gynaecologists, and paediatricians and state of the art hospitals benefitting from the not always well-informed patient.

2.4 ROLE PLAYERS IN INDICATIONS FOR CAESAREAN SECTIONS

In this section, the factors leading to caesarean sections are discussed, inclusive of medically indicated emergency caesarean sections, the patient's choice, the physician's choice, maternal conditions, and foetal conditions. Beyond clinical reasons for caesarean sections, non-medical reasons that are reported are often financial incentives, physician factors and maternal request (Monari, Di Mario, Fachinetti & Basevi, 2008:129).

2.4.1 Medically indicated emergency caesarean sections

A caesarean section is ideally done in cases where vaginal delivery is not feasible or would impose undue risks to the mother or baby (Dechenery et al., 2007:469). Caesarean sections can be elective if potential problems with delivery is considered in pregnancy. However, most reasons are only discovered in the active labour phase, in which case it becomes a real emergency, and the caesarean section procedure must be carried out when both the health of the mother and or the baby is at risk, for instance foetal distress and placenta praevia. The

prevalence of such an occurrence is increased with mothers not booking early enough in pregnancy, and then presenting with problems at the time of birthing. This however, according to the researcher's clinical observation, is much of a problem in the private health care sector than in public health care, with mothers having better access to good prenatal services, especially in the metropolitan well-resourced areas.

A caesarean section can be life-saving for mother and baby, for example in the second stage of labour, if there is no progress within the determined time for this stage. Several factors like lack of descent of the presenting part, foetal distress or impacted delivery can cause this situation. Vacuum or forceps extraction (use of medical instruments to help the baby through the passage at birth to complete the second stage of labour) can be attempted, but if it does not work, the baby should be delivered by caesarean section (Childbirth Connection, 2014:2).

Cord prolapse is another obstetric emergency that will require a caesarean section to save the infant, as well as placenta abruptio, in which case the mother should be saved from haemorrhaging and the infant from possible death due to lack of perfusion (Sellers, 2013:116).

Naidoo and Moodley (2009:253), furthermore, mention pre-eclampsia, cephalo-pelvic disproportion, prolonged labour, previous caesarean section and intra-uterine growth retardation as reasons for caesarean sections. Pre-eclampsia (presence of elevated blood pressure, protein in the urine after 20 weeks of gestation) usually begins in the second trimester and it can be life threatening for both the mother and the baby, usually leading to a premature caesarean section birth to save mother and baby (Sellers, 2013:239). Cephalo-pelvic disproportion occurs when the pelvis of the mother is too small to allow the safe passing of the baby's head through the birth canal (CIMS, 2010:4). Prolonged labour is defined as when a woman has been in the active stage of labour longer than the expected duration, mainly determined by cervical dilation which should be 1cm or 1.5cm per hour for the primigravida and multigravida respectively (Sellers, 2013:146). Intra-uterine growth retardation is when the foetus does not grow whilst in the womb as expected, due to reasons such as infection or placental insufficiency (when it cannot provide adequate nutrition for the foetus) (Sellers, 2013:320).

Furthermore, foetal indications for caesarean sections are the conditions of the baby that can warrant a caesarean section, for example foetal distress caused by cord compression or meconium liquor draining in latent or early labour. Foetal distress is an obstetric emergency

and presents with foetal bradycardia or tachycardia (Sellers, 2013:220). In addition, other factors include neonatal quality, instead of mere survival (for example foetal growth retardation), previous caesarean sections and multiple births, fear of litigation depending on the outcome of the birth in relation to the baby's wellbeing, and the use of intra-partum monitoring devices (Notle, 1998:494). Hydrocephalus causes the pelvic and vaginal passage to be inadequate for the baby's enlarged head, due to collected intra-ventricular fluids. Breech presentation is now also an indication for caesarean section as health practitioners are fearful of litigation should the outcome of labour be negative. Thus, fear of litigation overrides competence and it contributes to caesarean section prevalences (Mukherjee, 2006:298).

2.4.2 Patient's motivation

Fuglenes, Aas, Botten Oian and Kristiansen (2011:45) did a systematic review to determine what the women's preferences are when it comes to childbirth and found that active involvement with a natural birth are preferred when compared with the passivity of a caesarean section. Moreover, other studies discussed by these authors indicate that preferences towards caesarean delivery can be influenced by anxieties and fear of birth by women. Previous negative vaginal birth experiences also influence choice for the next deliveries, where women rather opt for a caesarean delivery.

Factors that would influence the private patient's choice of caesarean section as a birthing method include the fact that patient can have a choice over the birth date of her infant (convenience), so that her perineum can stay intact as opposed to the one who gives birth through vaginal delivery, and lastly, so that she can have better control over pain and the birthing process (Childbirth Connection, 2012:7; Turner, Young, Solomon, Ludlow, Benness & Philips, 2008:1471). Tjihenuna (2015:5) quotes a midwife in Namibia who said that "Only a handful of women personally opt for the procedure (normal delivery), also because mothers want their babies born on a specific date." The concept of mode of delivery being the patient's choice is well accepted among obstetricians, and in Europe, between 15 - 79% of obstetricians agree to perform caesarean section on patients' request (Karlstrom, Nystedt, Johansson & Hildingson, 2011:621). Thus, the decision for mode of delivery remains the autonomous decision of the women.

Other reasons for choice of caesarean sections include the fear of trauma and loss of sexual function or urinary incontinence (Lavender et al., 2012:3) that could potentially occur with a normal delivery, with women worrying about their relationships, and as a result they then

choose a caesarean section. VBACs are not a preferred method above elective caesarean sections in Egypt where a large proportion of women choose the latter (Abdel-Aleem, Shaaban, Hassanin & Ibraheem, 2013:119). A further study to understand decision making among pregnant women has found that most women who ‘demanded’ a caesarean section had fears for their own lives or that of their infants, or they had had a previous traumatic birth (Moffat, Bell, Porter, Lawton, Hundley, Danielian & Bhattacharya, 2006:87).

The fact that vaginal birthing may pose short and long-term complications inclusive of neuropraxia of the pudendal nerves, and direct trauma to the anal sphincter and pelvic floor are recognised by Turner et al. (2008:1471) and James, Wibbelink and Muthige (2012:404). However, a study amongst women who had previous caesarean sections reported that family factors are often the primary reason given for the mode of delivery, with VBAC being mentioned as having a quicker recovery period, but the opposing choice of a caesarean section bringing convenience in date and planning of the birth and the chance of concurrent sterilisation (Emmett, Shaw, Montgomery & Murphy, 2006:1439).

The ethical dilemma presenting here regarding the autonomy of the woman versus good clinical decision making is recognised by Nama and Wilcock (2011:266), who warn against the danger in devaluing expert clinical advice and judgment. Van Dillen, Meguid, Petrova and Van Roosmalen (2007:1) mention arguments which proffer that increases in the high caesarean sections are justifiable, with more choice being given to mothers towards this option. However, the opposite side of these arguments are also recognised by Van Dillen et al. (2007:1) that caesarean sections make childbirth more mechanical than natural and that some of the reasons given for this method of birthing are not justifiable. For Gallagher et al. (2012:40), caesarean delivery on maternal request is not a well-recognized clinical entity, nor an accurately reported indication for diagnostic coding when claims for medical coverage are dealt with by medical aids.

Wu, Kaimal, Houston, Yee, Nakagawa and Kuppermann (2014:440) report some evidence that suggests that patient choice influences the decision of a caesarean section during labour. However, it is of essence to note that decisions in the labour ward may not be directly influenced by the woman herself per se. According to Snowden, Martin, Jomen and Martin, (2011:2), the choice of a birth method is an act which requires connections between rationality and reason or risks and benefits, and hence the woman must be well informed prior to decision

making, so as not to make a swift emotional decision based on pain and discomfort experienced at the time.

Apart from women and caregivers, partners to the women also feel that they are to be involved in the decision-making process. However, in Sweden, a survey found that men did not mind which mode of delivery their women choose, as long as both the mother and the baby are well (Johansson et al., 2014:208). The same authors report that the birth process and the nature of birth is challenging for men as it triggers feelings of fear, anxiety and helplessness hence they support any decision with regards to mode of birth. Furthermore, fathers with previous negative birth experiences will opt or encourage their partners to opt for a delivery through caesarean (Johansson et al., 2014:209).

2.4.3 Physicians' motivation

In a gender-based survey done in the United Kingdom (UK) about mode of delivery, 17% of London's obstetricians (of which almost a third were female) verbalised that they would opt for an elective caesarean section in the absence of medical reasons, with their main concern being the risk of pelvic floor injuries (Turner et al., 2008:1471). Contrary to pelvic floor reasons, studies from South Africa indicated that the most common indication for the high rate of caesarean sections (standing at 74.6%) in the private sector of all the caesarean sections done electively, were that of a previous caesarean section (Naidoo et al., 2009:256).

Obstetricians are increasingly performing caesarean sections due to the risk to litigation, should anything go wrong during childbirth (Fuglenes et al., 2009:47). Abdel-Aleem et al. (2013:119) concur and state that elective repeat caesareans are preferred in Egypt, as in South Africa. In the rest of the African continent, some obstetricians are also reported as no longer being comfortable to advise for a trial of scar, nor do they have the patience for a trial of scar (Chen & Hancock, 2012:22).

The suggested reasons for the rise in caesarean sections in Iran, according to Shahoei et al. (2013:303), are the increased use of technology, with an overreaction to foetal monitoring, loss of obstetric skills such as a normal delivery for a breech presentation, litigation fears, and the pressure of time on the side of the obstetrician. Obstetricians are taught how to do external cephalic versions to ensure that the foetus lies correctly for it to deliver normally, but as they are not using these knowledge and skills regularly, some are not confident enough to do it

anymore. It could also harm the foetus if not done right, hence this is the main motivation why women are having caesarean sections with a breech presentation (Sellers, 2013:472).

Moreover, as indicated by Shahoei et al. (2013:303), the time involved with a normal delivery is also a contributing factor for the obstetricians. Women in labour require patience and monitoring, and this can be an inconvenience to the daily schedule of the obstetricians. In addition, doctors and obstetricians may be wary of the shortages or lack of nursing staff to continuously monitor the patients, as maternity is a high-risk department and all women in labour are considered high risk; yet with a caesarean section that then becomes a safer option to deliver (Naidoo & Moodley 2009:257).

As mentioned in Chapter 1, above all, obstetricians have ethical principles that guide them, including autonomy, non-maleficence, beneficence and justice and they should apply this when a patient makes a request for an elective caesarean section with no medical indications. However, Nama and Wilcock (2011:266) argue that in respecting the autonomy of the patient and devaluing expert clinical judgement, results in skilled obstetricians being reduced to technicians. Although it is the ultimate decision of the patient to choose the mode of delivery; it is also the duty of health care professionals to give full information pertaining to the mode of delivery so that women can make informed decisions.

2.4.4 Institutional indications

Institutions in this context are the hospitals where the caesarean sections are being performed. Whilst being interviewed about the status quo in Namibia, an obstetrician verbalised that there is no financial gain attached to performing caesarean sections for them, but that the hospitals are the ones that benefit financially (Tjiheununa, 2015:5). Furthermore, the conclusion is drawn that although these institutions reason that they have no say in the mode of delivery, they tacitly agree by not questioning the prevalence of the caesarean sections (Tjiheununa 2015:1). Khazan (2014:2) came to the same conclusion in the context of Brazil, and adds that the institutions can schedule more deliveries through caesarean sections than normal deliveries due to ulterior motives.

Moreover, with the aid of a systematic review, Hoxha, Syrogiannouli, Luta, Tal, Goodman et al. (2017:2) recognised the financial incentives for private providers and how this consequently results in higher caesarean section rates amongst for-profit hospitals.

2.5 ROLE OF THE MIDWIFE AND SCOPE OF PRACTICE

The ICM defines a midwife as a person who has successfully completed a midwifery education programme based on the competencies for basic midwifery practice and the global standards for midwifery education (ICM, 2014:1). The midwife is an independent practitioner who is governed by the scope of practice under the Nursing Act (Sellers, 2013:11) of the specific country. According to the American Nursing Association (2012:1), the role of the registered nurse is to provide coordination of patient centred care, especially when it involves patients that are at high risk. The ICM views the approach of midwives to childbirth as a physiological and a psychosocial process in the woman's life, which helps to optimize the experiences of women during childbirth, thereby helping them to prepare for motherhood (ICM, 2014:1). The role of the registered nurse/midwife is a complex one as they partner and complement the role of doctors by providing a holistic assessment to create links with different members of the health care team (Canadian Family Practice and Nurses Association, 2013). In low risk pregnancies, midwives are used to work independently when caring for the mother and infant before, during and after pregnancy (ICM, 2014:2).

According to Searle, Human and Mogotlane (2009:109) a midwife, like the doctor, has an expressive, as well as an instrumental role. However, the extent to which these roles differ from the doctor's is important in understanding the midwife's responsibility and relationship to the woman in confinement. The instrumental role as described by Searle et al. (2009:109) focuses on the midwife being able to gain knowledge about the needs of the patient through observation. Thus, it includes using the nursing process to assess the needs of the woman to formulate diagnosis and help in the intervention to ensure that the woman receives optimum care. In her instrumental role, she fulfils all the actions to ensure a safe delivery.

In fulfilling her expressive role, the midwife strives to establish and maintain the intervention or care that the woman is receiving, as well as the health of the woman, and assesses the need to collaborate with other health care professionals for the positive health outcome for the woman. In addition, they support the women with basic care, thereby demonstrating concern and a caring attitude towards women in this process (Searle et al., 2009:108). In her expressive role, she builds her relationship with the woman in labour and demonstrates her caring role. In the public hospital scenario, the midwife delivers both a largely expressive (emotional support of the woman) and a similarly large instrumental role (the full management of the labour process from start to finish, and discharge of the woman from the hospital).

Apart from the instrumental and expressive roles, the role functions of a midwife need to be explained. These independent, dependent and interdependent role functions describe the personal responsibility on the part of the midwife on the actions they take whilst delivering care (Searle et al., 2009:109). The three role functions are not independent of one another, but they are intertwined. In private hospitals, policies regarding different role functions differ from those of the public hospitals.

The dependent role function of the midwife in Namibia is governed by the Nursing Council under the Nursing Act No 8 of 2004 which ensures that all practising midwives are registered, thus ensuring their legibility to perform duties, and to perform within their scope of practice as such. The WHO guidelines are key to the formulation of health legislation and they guide the Namibian hospital policies in the clinical areas. Organisational policies are furthermore, affected by state, regional and local laws designed to curb or prevent abuses. Therefore, the midwife in any setting has the need to familiarise herself with state, regional and local laws influencing the conditions of employment, legislation of labour and health policies relating to compensation so that the midwife can comply with these (Booyens, Jooste & Sibiya, 2015:34). In this way, the dependent role of the midwife is guided by the policies of their specific hospitals and institutions of employment, which provide parameters for them; this is a certain order to ensure that clinical actions that are conducted are to the benefit of the patients in all circumstances.

The midwife's independent role function expects of her to function in a specific scope of practice, and as such this makes her accountable for whatever action she takes. The scope of practice of a registered midwife in Namibia involves "... the scientific application of the principles of midwifery and the provision of assistance and medical care to a patient undergoing labour and childbirth.... applicable to health care practice relating to a patient in the course of pregnancy, labour and puerperium" (Republic of Namibia, 2004). As such, the midwife should care for the woman and ensure a healthy pregnancy and childbirth, so it is imperative that the midwife be involved with the care of and decisions made regarding the care of the woman. In private hospitals, there is a contractual relationship between the midwife and the institution, as the institution employs the midwife and the midwives only care for the women within the antenatal period just prior to delivery, during the delivery, as well as the postnatal period prior to discharge. The women (patients) are clients to the midwife through

the hospital they are contracted to, and at the same time the midwives are also there for the patient when the patients present in the labour wards for delivery (Tjihenuna, 2015:5).

The midwife is independent in her decisions and she is equally accountable like the doctor; hence she cannot agree to all the decisions the doctor makes if their knowledge and experience dictate the opposite (Searle et al., 2009:109). Under her independent function she has prescriptive, organisational and implementation functions determined by the nursing process, which involves independent assessment, diagnosis, treatment and care, according to Searle et al. (2009:109). In line with the above, the midwives are governed in their scope of practice to execute the nursing process and through working with the doctor, they agree to implement the prescription the doctor has made or otherwise disagree with these orders as the midwives are answerable for their own actions (FIGO, 2014:94).

The interdependent function of the midwife in Namibian private health care institutions is to work together with the doctors when monitoring the patients in labour, and the doctor will then conduct the delivery. The private sector however, does not limit the role of the midwife in cases when the doctors are not in time to deliver their own patients, as they are enabled by their training to conduct deliveries. Thus, midwives coordinate with the doctors to have a good outcome for the health of the mother and neonate, and this also includes high risk women or those who may develop complications (Searle et al., 2009:110).

2.5.1 Midwives as advocates in the labour wards

Advocacy according to ICM (2018) is more than encouraging women to have a normal birth but extends to quality access to health services, equity and leadership. Furthermore, midwives need an environment that enable them to carry out their role in giving care to the women and also leadership roles and opportunities that help in the formulation of policies to intervene in childbirth only when necessary.

In Sweden, midwives' attitudes towards the mode of birthing indicate that they believe that it is the autonomous decision of the woman to choose the mode of delivery, bearing in mind that all information has been given to the patient to help them choose the mode of birth (Gunnervik, Josefsson, Sydsjo & Sydsjo, 2010:38). The Midwifery 2020 policy as motivated for by the National Health System of the UK is an attempt to put into practice the delivery of women-oriented expectations. The midwife as an advocate for the woman, will strive for effectively providing services that are respectful of and responsive to preferences of individual patients'

needs with patient values guiding all the clinical decisions with regards to mode of birth (Kennedy et al., 2010:29).

Midwives have a mandate of serving as advocates in their scope of practice, to ensure that the rights of the patients are not violated in any manner (Republic of Namibia, 2004). In Turkey, where the majority of pregnant women receive prenatal care from doctors, their Midwives Association (in trying to curb caesarean sections) has now cooperated with other empowering stakeholders for them to become more involved by providing prenatal care to low risk women. Midwives can contribute largely to women's health by providing information on necessary topics to empower them to make informed decisions and to advocate for vaginal delivery (Boz, Teskereci & Akman, 2016:2).

In the Netherlands, midwives are the primary caregivers of low risk women and as their advocates throughout their reproductive years, they also empower them to make informed decisions with regards to their health care and birthing methods, with a resultant low caesarean section rate. As a result, the Dutch association of gynaecologists stated in 2008 that the clinical midwives are a valued addition on the obstetric team, with their specific knowledge of the physiology of pregnancy, birth and the puerperium (Wigers & Hukkelhoven, 2010:2). According to the above report, the number of practicing midwives in primary care services increased from 1.042 to 1.871, with a great increase in midwifery-led care (Wigers & Hukkelhoven, 2010:2).

The Royal College of Midwives has a Midwifery toolkit, that gives midwives a mandate to be advocates, which includes the protection of the clients in assisting them to make informed choices. This toolkit supports midwives for them to be the client's voice when required, and to help towards conflict resolution in the labour wards and towards general reproductive health. In addition, they have suggested one-on-one midwifery support in established labour to help the woman emotionally and to help the woman to make informed decisions (Ross-Davie, 2012:4). FIGO (2014:95) believes that each woman has the right to positive birth experiences and compassionate care from skilled and knowledgeable health personnel.

2.5.2 Responsibilities and effect of ante-natal care and education

Antenatal health care includes the provision of a vast amount of information on nutrition, medication and preparation for birth (Gunnervik et al., 2010:40), which should be delivered harmoniously by whoever provides ANC to the patients. Such information should be provided

consistently and without contradictions, inclusive of the possible need for an emergency caesarean section to save both the mother and the infant (Chalmers et al., 2010:49). In addition, fear of childbirth can be dealt with during the antenatal visits in planning how to deal with the pain, and what to expect to make the experience less anxiety ridden (Ross-Davie, 2012:6). As such, antenatal care must be incorporated to suit the patient first and foremost.

Notle (1998:32) states that midwives have better relationships with well-informed patients, as they cooperate better in the labour ward, even if it is their first contact with the midwife. In the public sector, health education is given to all mothers at the beginning of antenatal care sessions at the clinics, before the women are individually attended to (McLaughlin, van Olst & Whelan, 2010: 106). However, most Namibian women accessing private health care receive ANC from doctors only, thus the health education received may not be adequate, as the numbers of patients awaiting consultation in doctors' rooms dictate the amount of time the doctor spends with one patient. Thus, the problem is that a midwife enters the scene only on admission of the doctor's patient at the hospital for delivery, which is a very late stage to establish rapport, with resulting trust issues coming at play. This may lead to poor communication and understanding of each other, with expectations not being met regarding labour techniques and maternal effort, and a prolonged second stage, which can negatively affect the prognosis and learning ability of the new-born later in life (Notle, 1998:22). Anxiety influences how women cope with labour, and this can be experienced because of the new environment and unfamiliar people dealing with them, unlike with environments and people they have known for the whole pregnancy (Mackenzie, 2017:10).

Decision making in the labour ward should be shared between the health care providers present, and the woman who gives consent for the procedures to be done on her. The information offered should help towards an informed decision (Kaimal & Kuppermann, 2016:384) for both women and their respective families towards an appropriate mode of birth (Boz et al., 2016:2).

2.6 SUMMARY

In this chapter, relevant literature from around the globe, regional and local Namibian context was reviewed to investigate the factors that influence the choices women make in delivery methods. The role of midwives as advocates in decision making in the labour wards was also included in the literature review, together with investigations on the use and subsequent outcomes of the Robson classification globally as an indication for performing caesarean sections. Literature in support and against decision making in the labour wards for mode of

delivery was included. The next chapter present in detail the methodology of the study followed.

2.7 CONCLUSION

In this chapter, the literature review displayed the gap in knowledge regarding informed choices of mode of delivery made in the Namibian context. Only a handful of studies were available to review with regards to choices of mode of delivery in Namibia. This study sought to understand the views of midwives with regards to the mode of delivery in labour wards in Namibia.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The literature review for this study was discussed in chapter two, with an introduction of the knowledge that existed and the identification of gaps in knowledge about the topic.

The purpose of the present chapter is to describe the research methodology applied and the ethical considerations of this study.

3.2 AIM AND OBJECTIVES

The aim of this study was to explore the views of midwives on delivery method decision making in Namibian private sector labour wards. The more specific objectives were a determination of the views of private sector midwives in Namibia with regards to:

RO1 determining women' decision making on birthing methods in labour wards

RO2 understanding the use of the Robson classification for caesarean sections in the private sector labour wards

RO3 determining the role of midwives as advocates during the women's decision making about mode of birthing

3.3 STUDY SETTING

The study setting was two private hospitals in the urban area of Namibia's capital, Windhoek. The researcher chose Windhoek as a setting, as this city has three of the total of six private hospitals in the country that offer maternity care (one private hospital in Windhoek started operating in December 2016, thus it was not included in the study). The others are spread over the country and thus they are difficult to reach, due to vast distances (200 to 1200 km from Windhoek) between them. Furthermore, these other three private hospitals outside Windhoek also refer patients with complicated cases to the private hospitals in Windhoek, which have specialist care. Both of the chosen hospitals were appropriate for the study as they offer maternity care which is provided by midwives as employees of the hospital and the patients'

have their own private doctors to be admitted into the hospitals. The two hospitals A and B respectively have on average 145 and 120 deliveries in a month, accounting for both caesarean sections and normal deliveries. Research participants were interviewed at places of their own choice, which for their own convenience took place either at the hospital or at their homes.

3.3.1 Caesarean section rates

The two selected hospitals have a capacity of approximately 25 beds each. Bed occupancy varied in the two hospitals between 86 to 95%. As private hospitals, both hospitals served the middle to upper class socio-economic groups of the Namibian society.

The caesarean section rates for each hospital are not known, as the hospitals were not at liberty to provide such information to the researcher, rather they referred the researcher to the NAMAf where the researcher obtained the statistics for the total private hospitals in the country. The doctors that make use of these hospitals make use of both hospitals when they make referrals for their patients, depending on the patient's preference of hospital. One of the hospital has the advantage of having a separate maternity theatre, and in case of emergencies they can conduct the procedure fast, unlike the other hospital which has one main theatre for all kinds of general surgeries.

3.4 RESEARCH METHODOLOGY

A research methodology is defined as the systematic description of the procedure taken and explaining the phenomenon under study master plan for obtaining answers to the research questions (Polit & Beck, 2012:58). A research methodology is a clearly defined structure within which the study is carried out to achieve accurate results (Grove et al., 2013:194).

3.4.1 Qualitative research methodology

In this study, a qualitative research methodology was used, which addresses “fundamental aspects of reality with a desire to know more about the phenomenon which gives rise to a view” (Grove et al., 2013:265). The phenomenon studied was the high prevalence of caesarean sections. The views of the midwives regarding decisions made about birthing in the birthing period which give rise to the high incidence of the phenomenon were sought.

Qualitative research methodology is interpretive in the sense that it is concerned with the understanding, experience and interpretation of the social world (Masson, 2010:35), and thus provide a way to explore and understand the meaning that individuals and or groups ascribe to a social or human problem (Creswell, 2009:4). This study is classified as qualitative because

it also explored the “how” of the midwife as an advocate for the women’s choice of delivery method in the private sector.

3.4.2 Exploratory research design

This study was exploratory, and such exploratory research is often utilised when the subject under study is not well-known (Neuman, 2011:42), and when a problem needs a solution (Grove et al., 2013:27). Midwives’ perceptions (as witnesses and advocates in the antenatal period) about decision-making in the labour ward was the subject to be explored. This exploration was anticipated to help towards understanding the problem of Namibia’s high caesarean rates in the private sector, and then working towards addressing the situation from the research findings.

Furthermore, exploratory research identifies key issues to gain an understanding of a social setting (Maree, 2016:55). For this research, the key issue to explore was the reasons given for decisions towards performing a caesarean section as understood by midwives as role players in the private sector setting in Namibia.

3.5 POPULATION AND SAMPLING

Neuman (2011:246) defines population as “the concretely specified large group of many cases from which a researcher draws a sample, and to which results from the sample are generalized”.

An accessible population is the portion of the target population to which the researcher has reasonable access (Grove et al., 2013:351). Of the six private hospitals in Namibia as the total target population, two are situated in Namibia. These two hospitals provided the accessible population of midwives, approximating 35 making it the total population with 20 midwives in hospital A and 15 in hospital B.

Sampling involves selecting a group of people with which to conduct a study. Through the application of purposive sampling, qualitative researchers strive to select information rich participants that can provide and expand upon the data needed to achieve the study aims (Grove et al., 2013:268; 351; 365).

3.5.1 Selection of participants

A purposive sampling method was used in this study ‘to obtain an in-depth understanding’ of how women make decisions regarding birthing methods, how midwives support and advocate for their decision and how the Robson classification was applied in the private sector. The

approvals from hospitals (see Appendix 3) were received in December 2016 and the recruitment of participants took place from December 2016 to March 2017. A sample of 7 willing participants was obtained from the two hospitals to represent the population. Although the researcher anticipated recruiting and conducting 10 interviews, the sample size was determined greatly by the availability of the 7 willing interviewees, and by data saturation (Grove et al., 2013:371).

The participants' demographic characteristics in terms of years of experience as a midwife, age and cultural background helped towards ensuring variety. Midwives who worked in the public sector before were included, as their experience helped to shed light on the role of the midwife in the labour wards in the different settings.

3.5.2 Inclusion criteria

The inclusion criterion for the study was all the midwives working in the maternity departments for a minimum period of six months in one of the two private hospitals in Windhoek. No midwives working in the private hospital labour wards were excluded from the study.

3.6 DATA COLLECTION TOOL

The researcher used semi-structured, individual interviews because of their flexibility, open-ended character and the possibility for qualitative depth. De Vos et al. (2011:57) recommend that semi-structured interviews and qualitative analysis are a suitable combination when the goal is to explore personal and controversial issues. Such interviews are particularly useful when the subjective views of a research participant are needed. Interviewing is a flexible technique that allows researchers to explore greater depth of meaning from research participants (Grove et al., 2013:424). Individual interviews are essential as they ensure confidentiality and the anonymity of the research participant.

An interview guide (see Appendix 5) was structured with the topic of the research and the objectives of the research in consideration. Questions such as 'How do women decide on a birthing method when in active labour?' were asked. Open-ended questions were formulated in the interview guide to ensure that the data portrayed the participants' views.

3.7 PILOT INTERVIEW

A pilot interview is the initial step the researcher conducts to evaluate if the proposed interview procedures and the interview guide will address the phenomenon under study (Grove et al., 2013:46).

The researcher developed an interview guide to collect the data, and proceeded to conduct a pilot interview with a midwife from the first hospital. At the second hospital, a field worker, to whom the interview technique was demonstrated, joined the researcher. The purpose of these pilot interviews was to identify problems with the research design and to give both the researcher and field worker experience in interviewing and data collection. The pilot interviews took place in the same setting as that for the main study. While conducting the pilot interviews, the researcher found that some questions required clarification and the researcher reworded some questions on the interview guide. The pilot interview was co coded with the assistance of the supervisors to help the researcher understand the process to ensure trustworthiness. The data obtained from the pilot studies were suitable for the research study; hence they were included in the main study.

3.8 TRUSTWORTHINESS

Assessing trustworthiness in qualitative research is a complete test for analysing data, drawing findings and conclusions for any work (Maree, 2016:123). Trustworthiness in this study was applied during the preparation of data, organizing and reporting of results (Elo, Kaariainen, Kanste, Polkki, Utriainen & Kyngas, 2014:2). The data collected through interviews were transcribed, and the recordings together with the transcripts were sent to the supervisor for the confirmation of accurate transcriptions of the audio data. The supervisor checked for bias on how the questions were asked and how the interview was conducted. Handling and managing of the data was under diligent supervision of the supervisors and the researcher constantly all data to the supervisors. The study followed the four principles of trustworthiness in qualitative research, namely credibility, transferability, dependability and confirmability as discussed below.

3.8.1 Credibility

Credibility means that a true picture of the phenomenon studied is presented (Shenton, 2003: 63). Credibility in this study was accomplished by engaging with the research participants through in-depth, one-to-one interviews to be able to understand and portray the phenomenon fully. This was done by audio-recording the interviews and transcribing each recording

verbatim, listening to it several times and reading the content repeatedly to fully reflect on and understand what the midwives said. Bracketing (Creswell, 2014:40) was applied, and this helped towards ensuring credibility, with the researcher setting aside personal assumptions when interviewing and handling the data. Individual interviews were conducted to ensure that each interviewee's viewpoints were obtained, and their transcribed interviews were verified by the supervisor to ensure that the views and experiences of the midwives had been captured accurately and interpreted properly.

3.8.2 Transferability

Transferability means the extent to which the findings of one study can be applied to other situations (Shenton, 2003:69). To increase transferability, qualitative research focuses on two key considerations: (a) how closely the participants are linked to the context being studied, and (b) the contextual boundaries of the findings (Given, 2008: 886). In this study, midwives have intimate knowledge as they are part of the triad involved in the active phase in labour, and can shed light about decision-making about birthing methods in this phase. The contextual boundaries in this case are the private hospitals in urban capital of Namibia, Windhoek. One can surmise that this study's findings might be transferable to another Namibian private setting and possibly to some other private hospitals in the African context.

3.8.3 Dependability

The dependability criteria in qualitative studies are difficult, with researchers striving to enable future investigators to repeat the study in other settings (Shenton, 2003:63). Dependability becomes more realistic in qualitative studies if the researcher maps out the procedure and research instruments in a way that others can collect data in similar conditions (Given, 2008: 896). The researcher attempted to report on the research process in detail so that future researchers will be able to similarly conduct such a study and compare these methods and findings meaningfully. The researcher had the data and transcriptions checked by the supervisor to ensure their accuracy.

3.8.4 Confirmability

Confirmability serves to demonstrate that findings emerge from the research participants and not the researcher's own predispositions (Shenton, 2003:63). Bracketing of own views was applied to ensure neutrality from the interviewers and the researcher to obtain only the research participants' views (Maree, 2016:125). The interviews were recorded, and the transcriptions made, with verification from the supervisor to ensure that the viewpoints of the research

participants were portrayed, and that the bias of the researcher was minimised in the presentation of the research findings.

3.9 DATA COLLECTION

Data collection is the gathering of information to address a research problem (Polit & Beck, 2012:175, Grove et al., 2013:525). The researcher used a semi-structured interview guide in the individual interviews with the participants.

3.9.1 Data collection process

The data collection process began in March 2017 and finished in April 2017. The researcher went to the two participating hospitals with participant information and consent forms (see Appendix 4), and these were left at the two participating hospitals by the researcher for the potential participants to read on their own time after explaining the aim of the study to the potential participants. The researcher spoke to the midwives that were on duty on two days for the reason of making sure that both shifts can be contacted. Not all the midwives were met at the hospitals as some were busy, information regarding the study was given to the midwives together in groups. This was done after permission was sought from the unit manager.

The researcher had to go to the participating hospitals for a second time to recruit the participants as there were no research participants that had contacted her after the initial recruitment. With the second recruitment the researcher made it priority to meet all potential participants when they were free to explain the nature and purpose of the study. The researcher communicated to the potential participants and advised them to contact the fieldworker and or the researcher on the telephone numbers provide to indicate if they were interested to participate in the study. Subsequently, the research participants contacted the researcher and fieldworker, and arrangements for the place and date for the interviews were made. The research participants were met at the places of their choice for the interviews, thereby contributing further to autonomy.

On the day of the interview, the participant brought the signed consent forms along. Only the seven participants who contacted either the researcher or fieldworker were interviewed. The researcher conducted interviews for hospital A, and the field worker for hospital B, with the researcher and field worker working closely together towards reaching the objectives of the study. After the interviews were conducted and analysis had begun, the researcher in

consultation with the supervisors was satisfied that enough and quality information was gathered hence data saturation was achieved.

Verbal consent was recorded with every interview, even if a written consent had been obtained. The research participants were not addressed by their names during the interview as well as in the transcriptions; instead codes were used to ensure anonymity as well as beneficence and non-maleficence in an effort towards the reduction of fear of victimisation. Interviews were each conducted over a period of one hour, for the comfort of the research participants, during which refreshments were offered. The research participants were allowed to discontinue their participation at any stage of the research if ever they wished to do so.

3.10 DATA ANALYSIS

Data analysis is the process of examining and interpreting data to elicit meaning, gain understanding and develop empirical knowledge (Grove et al., 2013:279). In qualitative research, data analysis happens concurrently with data collection. The research study followed the six steps of data analysis by Creswell (2014:63) as described below.

Step 1: Prepare and organise data

Interviews were conducted and recorded, and these interviews were transcribed verbatim by the researcher (see Appendix 6 for a partial transcription). The researcher listened to the recordings many times to ensure that the transcriptions were accurate. The researcher sent all the interviews and transcriptions to the supervisors who perused them for mistakes in correlation between the voice recording and the transcription.

Step 2: Exploration and coding of data

The researcher printed out all the transcripts and re-read them, to familiarise herself with the views of the midwives. By reading and immersing herself in the interviews, the researcher obtained a general idea of how midwives understood the way decisions are made in their respective labour wards. Grouping of similar ideas was done out of the printed transcripts, using colour codes for the different themes which were found, to ensure that the data is manageable. Through the coding of the data, the researcher could identify recurring patterns and ideas.

Step 3: Coding to build description and themes

Coding continued in this step, with themes and sub themes being grouped together by identifying repeating ideas and phrases. The coding made the data manageable, and helped towards further building and finalising of descriptions and themes. This step also consisted of ensuring that the research objectives were addressed, and in developing an in-depth understanding of the views of midwives with regards to decision making in the labour wards.

Step 4: Represent and report qualitative findings

The researcher discussed each theme and subtheme, with illustrations of the midwives' opinions via direct quotations. Assumptions and conclusions were made from the participants' responses. The researcher also presented the themes and subthemes in figurative form at the beginning of chapter 4 as a preview to the discussions.

Step 5: Interpret findings

The themes and subthemes of the research were interpreted with connections made between them. These themes and subthemes were discussed in a narrative form to represent the findings of the exploration of the phenomenon, to better understand and address it. Deductions were drawn from significant findings and these were used to write the final report and to make recommendations.

Step 6: Validate accuracy of the findings

Transcription was done by the researcher herself. The voice recordings were changed into a compatible form for them to be sent to the supervisors through email. The supervisors perused the audio files and transcriptions to determine their accuracy, and they gave the necessary feedback to the researcher regarding the interpretation of the themes and subthemes. The literature study findings were compared to the findings of the study, and comparisons were made to determine if the findings were similar or different, with an honest discussion of all relevant findings. The final chapters of the thesis were written, with continuous feedback from the supervisors to ensure authenticity in the portrayal of the research participants' opinions about decision making in the labour ward.

3.11 SUMMARY

A total of seven interviews were conducted in the two chosen hospitals in the private sector of Namibia by a field worker and the researcher, to obtain data for this study. Voluntary participation was ensured as participants had the opportunity to withdraw at any time. The

interviews were recorded and transcribed verbatim by the researcher. A brief description of the analysis was given in this chapter and the next chapter will deal with the analysis in detail.

3.12 CONCLUSION

An explorative design with a qualitative approach was used in this study. The use of purposive sampling was done with midwives working in the private maternity units for more than six months. Ethical considerations were applied during the collection and handling of data. Informed consent forms were signed, and no names were used throughout the research process.

CHAPTER FOUR

FINDINGS

4.1 INTRODUCTION

A presentation of the data analysis is dealt with in this chapter. According to Grove et al. (2013:279), data analysis is a process of interpreting and examining data to elicit meaning, gain an understanding and develop empirical knowledge. The research methodology that was applied in this study was discussed in chapter three. In this chapter, the findings from the data collected from the Namibian midwives as participants of the study are described. The data was collected via individual interviews with the midwives working in the maternity departments of two private hospitals in Windhoek.

4.1.1 Aim and objectives of the study

The purpose of the study was to explore the views of midwives regarding decision making about delivery methods in the Namibian private sector labour wards. Furthermore, as the objective of the study, the researcher sought to understand their perceived role as advocates in the labour wards, and the use of the Robson classification in their workplaces. The findings are presented and displayed using direct quotations from the participants.

4.2 WORK EXPERIENCE AND DEMOGRAPHY

The first part of the interview requested the research participants to indicate their years of experience as midwives, and their years of experience at the current workplace. Their responses are indicated in Table 4.1 below.

Table 4.1: Work experience and demography

Pseudonym of participant	Gender	Years of experience as midwife	Years of experience at current work
P1	Female	26 years	6 years
P2	Female	6 years	Not specified
P3	Female	8 years	Not specified
P4	Female	12 years	7 years
P5	Female	11 years	6 years
P6	Female	4 years	2 years
P7	Female	2 years	2 years

Both private hospitals from which the midwives were interviewed were situated in Windhoek, the capital of Namibia. The selected research participants were midwives with more than 6 months of experience in these private hospitals as their workplaces. They were all female, with experience both in the public and the private sector, ranging from 2-26 years.

4.3 THEMES FROM THE INTERVIEWS

The themes and sub-themes which emerged from the findings show the unique dynamic relationship within the private sector between the role players involved in the obstetric care of the women in the perinatal period and how these relationships influence each party's decision making, with special reference to the midwife and the patient in the birthing period. The findings of this study were categorized into four themes (see Figure 4.1 below) derived from the qualitative data analysis. The four themes were developed from the four role players' interaction within the study setting. These role-players were identified as the midwife, the doctor, the institution and the woman in labour as the patient. Moreover, nine sub-themes were drawn from the main themes which helped to explain the views of the midwives with regards to the specific influence of the different role-players on the patients' decision making about the mode of delivery.

The following figure (Figure 4.1) is a graphical presentation of the data emerging from the study presented in the abovementioned themes, with their subthemes in brackets as follows: midwife (dependent, interdependent and independent role functions); doctor (dependent, interdependent and independent role functions; instrumental and expressive roles; motivations for C/S); patient (ANC and expectations of pain management in labour; present support or birthing partner); and hospital (policies and guidelines; Robson classification). The focus revolves around the patient in the centre, with some intricate interconnections linking all the role-players, with interdependency amongst them in fulfilling their necessary functions in delivering maternity (or obstetric) care.

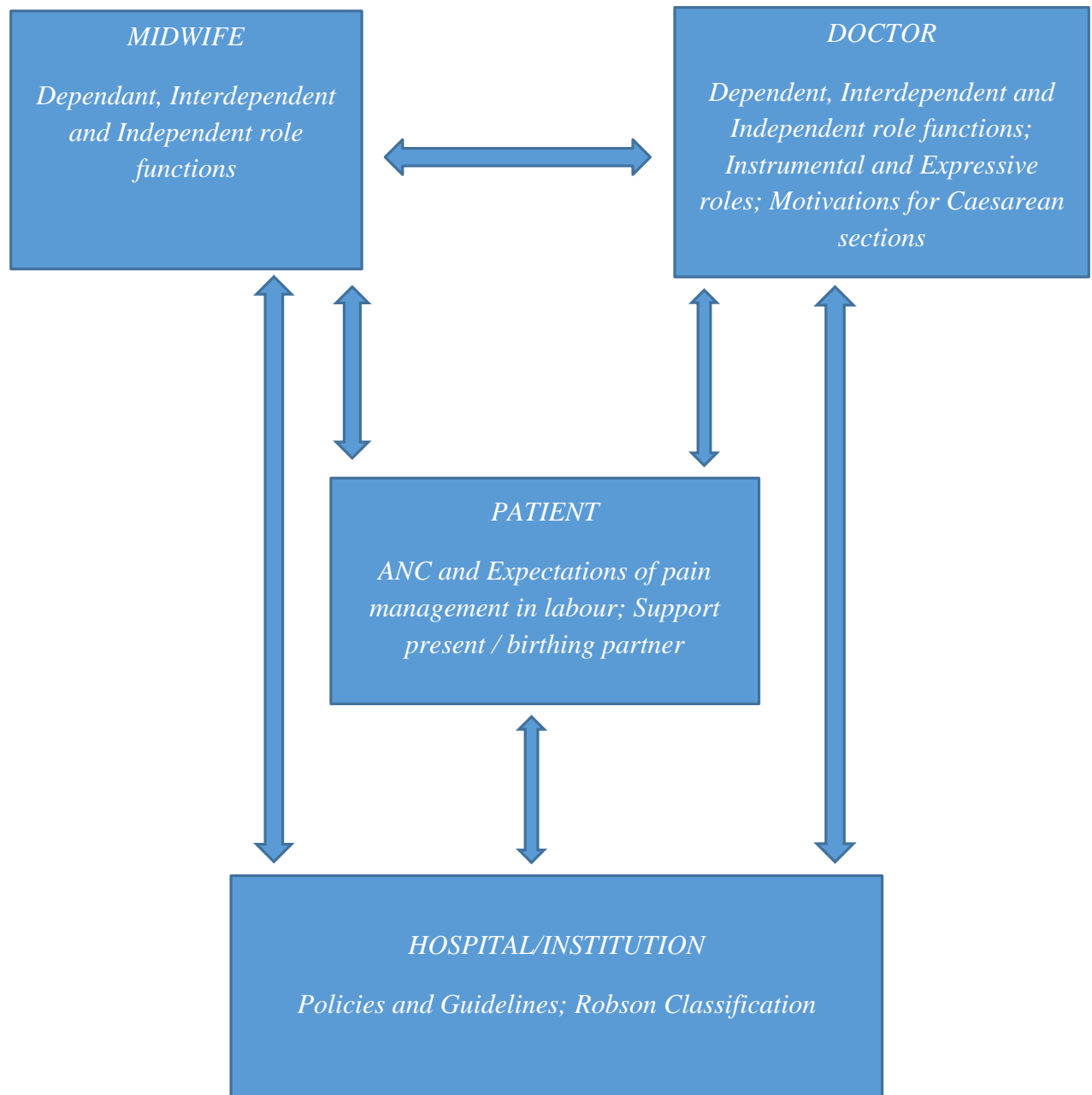


Fig 4.1: Thematic representation of analysed data

4.3.1 Theme 1: Midwife

The first theme focusses on the midwife as the main respondent of the study. Within this theme, the dependent, interdependent and independent role functions of the midwife are discussed. The findings indicated that midwives' role functions in Windhoek, Namibia, are dependent on legislation and hospital policy, with the scope of the midwife's independent role function being influenced by the private setting. Furthermore, interdependence exists between her and the doctor and the institution in delivering care to birthing mothers. Specifically, the

amount of their input in each of these role functions in the perinatal period contribute towards their dis/satisfaction with their influence on the patient's decision-making power in the birthing period.

Professionally, midwives are trained to fulfil a primary caregiver role, and they manage to do so in the public sector, but the private sector in Namibia has allocated this primary care giver role mostly to the doctor. It was found that the role functions of the midwife in the private sector of Namibia include a larger interdependent than independent component. It was indicated that they are there only to monitor the patients in labour, while the decisions of the patients are made or influenced by the doctors alone.

The theme of the midwife is discussed by way of his/her different role functions (dependent, independent and interdependent) as the subthemes, as they play out in the private sector.

4.3.1.1 The dependent role function

In fulfilling the midwife's dependent role function (Nursing Act no 87 of 2008), he/she is expected to be knowledgeable of governmental legislation and hospital policy in executing his/her tasks. The Namibian government is actively encouraging women to give birth normally and hospitals to reduce the rate of caesarean sections. Midwives in such a setup are active birth partners and they must refer to the doctors if there are any complications with normal physiology, and the doctor will decide on a plan of action, depending on his/her assessment. This puts the midwife in a difficult position as a private hospital employee, as his/her loyalty might be divided between that which the government prescribes and advocates for, versus that which his/her private employer expects. Although one would expect that policy formulation in hospitals follows legislation from the government, the opinions of the government and the private sector do not necessarily converge to result in such a step. This is illustrated by one participant's views below, who mentioned that private doctors in Namibia focus more on dealing with pregnancy as if it is a problem, instead of it being a natural process, with the midwife having a more subdued expressive role when compared to midwives from other countries.

PI "So, I think they (the doctors) have a quite different point of view to pregnancy and birth because they will always look for pathology and would.... (attempt) to prevent pathology I have the xxx (international setting) experience and I have this

experience here in Namibia, and definitely in xxx (the other international setting), the midwife is much more present in the care of patients.”

This situation then poses an uncomfortable moral dilemma that they need to live with, or deal with actively in their workplace.

4.3.1.2 The interdependent role

A midwife has an interdependent role with other health care providers, as these other professionals' expertise is needed for the positive health outcome of the patient. Midwives acknowledged their interdependent role with the doctors in the public sector when there is a need to consult which arises due to complications with the patient's pregnancy, but the interviewed midwives bemoaned the fact that this role is enlarged to the detriment of their own independent role in the private sector.

P2 “... at the government setting... its better where the doctors they come and you have to call them when there is a problem...”

P4 “... in the state for me, I feel I was practicing what I learnt from school, while in the private I am really limited.”,

The midwife in the private hospital labour ward in Windhoek Namibia has a much bigger interdependent role function, as the patient is the client firstly of the doctor, and then of the hospital and lastly of the midwife. Therefore, most of what needs to be done to the patient has to be cleared with the doctor, or it depends on the doctor's standing orders and the policies of the hospital.

This also indicates a restricted scope of practice for the midwife in the private health care sector of Namibia, as opposed to the public sector as illustrated below.

P1 “I'm employed as a nurse and midwife in the hospital. The work I am doing there is very much of taking care of a woman in labour, but I am not the one who is in charge of what is happening in there. Umm decisions umm concerning how the delivery is managed, or how the birth is managed are fully with the doctor. I don't have a lot of say in that regard. So, I am more – I feel I'm more assistant of the doctor than I'm being an independent midwife and doing midwifery work there in the hospital.”

P3 “I do not feel the hands-on experience of being a midwife what we were taught at school where I am working...”

In being forced to be more interdependent, midwives feel disempowered, which might have an influence on their self-esteem and assertiveness in the private sector.

4.3.1.3 Independent role function

The independent role function of the midwife includes doing an assessment on the patient, planning interventions according to these findings, implementing the plan (inclusive of the birth plan agreed upon by the doctor and the patient), and evaluation of the intervention. If the midwife, due to his/her knowledge and experience does not agree with what the doctor prescribed, he/she should be able to reason and justify his/her arguments as an independent professional accountable for his/her own actions. In assessment of the situation (his/her instrumental role), and applying his/her expressive role which indicates a caring relationship with the woman in labour, he/she wishes for the woman's initial birth plan to be followed through, so that women can be allowed to give birth without unnecessary interventions.

P1 “...a midwife would actually try to support the normal things happening during labour.... since midwives have a more physiological view on birth, like it's something which happens to every woman and it's a normal process which needs to be observed.”

P5 “So we also encourage them to go for normal delivery if it wasn't for cephalo - pelvic disproportion - like (the) baby can't pass through the pelvis bones because they are small...”

Private patients have their pregnancy monitored by doctors in the antenatal period before admission for active labour. Once the women are in labour, the doctors in the private sector rely and work together with the midwives in the obstetric wards. Midwives in this scenario have little opportunity to talk with women regarding perinatal matters and to help them decide for a normal delivery, as this education is assumed to have been discussed already by the doctors in the antenatal care period. However, a more collaborative educational effort would be beneficial as both the doctor and midwife will at some point be involved with the woman. In Namibia, medical aid societies/schemes usually dictate the circumstances of the antenatal period and birth together with the motivation of the private doctor of the patient. The hospital, and the midwives as the employees of the hospital, must accommodate the doctor as the client, and honour the relationship between him/her and his/her patient.

P1 “we have the private population – the population who has private insurance and for them, midwives are not available (as private practitioners), they go to a doctor.”

Frustration is expressed about this status quo, as in the state hospitals where some of the midwives had trained and have had some work experience, opportunity existed to build a trusting relationship with the patients (the midwife’s expressive function). At the state hospital, the midwife was the first point of contact on booking and the midwife provided continuity of care perinatally, with total responsibility for the woman in labour. In the private health care setting however, they meet the women for the first time when the women come to the labour ward to deliver, missing the full nine months of preparation for birth.

Thus, the midwives’ expressive roles are limited because of the short time the midwife spends with the patient between the time of admission and delivery (which is a matter of a day or two). As such, there is a lack of established rapport in the final part of the pregnancy, which limits the midwife’s role to assist women in making informed choices, as they have not managed to build a trusting relationship yet. This view is supported by the following interviewees:

P1 ‘So, if a woman comes into labour, they meet me, most of the time(for) the first time in their life, so they don’t know me. They don’t know what my opinions are.’

P3 “but it’s very few times that a patient would eventually ... decide on the midwife’s advice”

Furthermore, the nurturing expressive role the midwife must fulfil during the very intimate period of giving birth starts with a poorly laid foundation.

The reversed roles in the private sector have the doctors responsible for the patient in the antenatal period and doing the delivery time. In this perinatal period, the role of the midwife is also reduced to just that of monitoring during the labour process. The midwives thus experience less work satisfaction as they do not apply what they were taught in their training when delivering the infant themselves.

P1 “Yes, we have the state system where they go to the clinics and where they deliver in state hospitals, where they are cared for by midwives (for the whole perinatal period),

P3 “Ya currently where I am working – ok, midwifery is kind of, like it’s fine. The experience is fine, but you don’t really feel hands on as a midwife because it’s - it’s a private institution where most of the things are done by the doctors.”

Although frustration exists about the limitation of role functions, the midwives are aware of their important role of being vigilant in monitoring the labouring women in their care, to ensure that both mother and baby have good outcomes. The midwives mentioned that when they monitor the patient, they continue to value that patient as important, despite them not having the overall control of the decisions in the labour wards.

P2 “I am monitoring, that’s the most important part of midwifery. ... if I am able to detect a problem and tell the doctor, then I am useful ...so if there is a problem ... that the patient is not going to deliver normally... then we call the doctor”

Midwives thus take pride in being able to detect problems during monitoring of the patient and to ensure that the doctor takes their concern seriously. Under such circumstances, the role of the midwife does move beyond simply monitoring, towards being an active role player in the decision-making processes. He/she advises the doctor on the patient’s status and influences his/her decision making, being more aware of the small nuances of the labour process, especially regarding noticing the appearance of subtle risk factors.

P4 “When we are taking care of the patient that moment, because you are the one who is more in contact during the labour process, that is the time you pick up certain things. Then it is the right of the nurse to tell: but doctor I think this patient needs this care instead. Because at least you have been seeing she is progressing or not, then you can make suggestions to the doctor.”

The partograph as a tool to help towards monitoring enables early detection of problems for which medical interventions are needed. In using this tool, they become more independent as it acts as a guideline towards proper care. This tool is effective, that in the public sector the doctor is called only when the warning lines on the partograph are crossed, enabling them to deal with the whole perinatal period themselves if crossing of the lines does not occur:

P2 “a partograph is a guideline for the action of a midwife. It gives me an indication (when) to call for (help)”

Decision making with regards to the mode of delivery thus emanates from knowledgeable interpretations from the partograph, which gives empirical support to their observation and interpretations.

However, as the ultimate decision lies with the doctor and the patient, often the midwife's voice is ignored, as it might suit the doctor to take the caesarean section route. Midwives feel that their advocacy role towards normal deliveries is not taken seriously by their colleagues, the doctors, in the birthing process. This creates the feeling that they are ignored. Once their voice is ignored, and this situation is accepted, it becomes the norm, as their gatekeeper role is transgressed, and increased caesarean sections rates result.

P6 “as a midwife, as a nurse, there is nothing that you can do, you just prepare the patient and take the patient to caesarean section.”

Moreover, at times their independent role of advocating for the patients is not practiced, simply because there is no time for the midwife to provide advice, as they are overwhelmed with work in their units. Consequently, there won't be a chance to talk to the doctors about the proposed management of the patient, as the midwife might be preoccupied with the provision of monitoring services to other patients.

P1 “...trying to advocate for the patient (so) that things are done differently – if it is very busy, it's extra effort and it might not happen, because you are just too busy to challenge a doctor's decision.”

Thus, although the midwife is the more constant companion of the woman in labour and generally more aware of the nature of the labour progression, the doctor does not feel obliged to take the suggestions, being the primary care-giver of the patient.

4.3.2 Theme 2: Doctor

The doctor's role in the decision-making process in the private labour ward is that of the primary care giver and decision-influencer to the women in labour. Ultimately, the doctor as the specialist makes the decision regarding the necessity of a caesarean section. Indications for caesarean sections are therefore narrated under this section to elicit how decisions are made in the labour ward in determining the mode of delivery.

The doctor in the private sector has an interdependent relationship with the midwife during the care of the patient as the doctors are not present for continuous monitoring of the patient during

the labour and the post-partum period. What makes the relationship of the doctor and midwife in the private sector different from that in the public sector is that in the first instance, the doctor also cares for the low risk pregnancies that do not have pathological indications. The doctor can make decisions for his/her patient without consulting the midwife, as the doctor has no contractual relationship with the midwife, but only with his/her patient. The same goes for the relationship the doctor has with the institution; the doctor in the Namibian private hospital labour wards is an independent entity who makes use of the facilities and human resources of the institution and makes independent decisions that concern the patient.

4.3.2.1 *The dependent, interdependent and independent role functions of the doctor*

The doctors that practice at private hospital labour wards are either general practitioners or obstetricians, depending on whom the patient has chosen to attend to her pregnancy and delivery. A doctor in obstetrics deals with pregnancies, and in most settings where there are mainly midwives responsible for women perinatally (as in the public healthcare services), the doctors only deal with the pathology of pregnancy and labour. Their dependent role function is governed by the Health Professions Council of Namibia, as with the midwife. As such, their scope of practice is much wider, and thus private hospitals and medical aid schemes give them the right to determine how the delivery will take place. This is opposite to the public sector which is bound by strict policies and procedures as determined from legislation. Their independent function thus includes the delivery of antenatal care from first diagnosis of pregnancy, the delivery, as well as the postnatal period. For them, the only reason to engage with a midwife for their patient's care (the interdependent function), is during the short period of hospitalisation for monitoring of the birth process, until the woman (and new-born) is ready to be discharged and able to manage at home.

The doctor works interdependently with the institution, as the institution provides a 24-hour nursing and surgery team standby service, which would be unaffordable for the doctor to provide professionally otherwise.

4.3.2.2 *The instrumental and expressive roles of the doctor*

Although doctors in the public sector have a more instrumental function towards their patients, those in the private sector have a much bigger instrumental as well as expressive function. This is because they are private practitioners, and they have to maintain a relationship with their patient, to keep their patient for following pregnancies, and apart from earning an income, to also earn a good name.

P4 “We are not involved because private patients only come to the private hospital for delivery or when they have problems for admission, but most of the times they are with the doctors.”

P3 “so we really don’t really have much power or influence on the doctors. Where I work, the patient, the doctor has the ultimate say in everything.”

The private doctors thus have the responsibility of ensuring that the women have all the information that they need during pregnancy and the birthing process for facilitating decision making. Therefore, the doctor, not the midwife, exerts a direct influence on the patient’s decisions.

4.3.2.3 Motivations for caesarean sections

Private doctors share their opinions regarding the risks involved for mother and infant antenatally, and this influences the mother’s decision towards a specific mode of delivery

P3 ‘it depends on what they would have discussed with their doctors’

P4 ‘and the doctors’ decision that I think the baby is too big...’

However, according to midwives, at times doctors fit the delivery of patients into their own personal schedules, for instance when the doctors might have many patients in their rooms waiting to be attended to. This can influence the doctors’ motivation to do a caesarean section, as the labour period cannot be predicted, and they do not want to wait. Therefore, convenience as a reason on the part of the doctors was quoted by most of the midwives who also expressed concern about this status quo.

P3 ‘I feel - some Caesars are done for their own convenience. Like they need to go for Easter holiday, Christmas holiday, and they are having this much patients.’

P5 ‘But, it’s just that they don’t have patience to wait for the normal labour as it should go, maybe because they want to go somewhere, (or) they don’t want to be woken up at night to come and conduct the delivery, or maybe they are scared of complications’

Arguing that convenience is given as a reason for a caesarean section is especially a possibility when the patient experiences poor progress during labour. The midwives’ opinions indicated that some patients, especially first-time mothers, come in too early and they are then confined

in the ward to deliver, even when they are not in established labour, instead of being discharged. However, if they are confined in hospital, and active labour does not follow, they are classified as ‘poor progress’ or ‘prolonged labour’ as a valid reason to perform a caesarean section. In such a case the patient becomes an aiding agent to an unnecessary caesarean section, owing to the patient being impatient, and not wanting to come in again when in true labour:

P3 ‘I don’t know if they are really carrying out their prenatal (information) where they are told when to really come to the hospital. So, others would end up being more than 20 hours admitted, though still in latent phases for primigravidas.... They come early and they would feel - I have been here for a long time, nothing is happening - then they could eventually decide: ah I want to go for a caesarean section...’

Thorough prenatal information given to the patient regarding differences in symptoms between false and true labour would have prevented such unnecessary admissions and the subsequent surgery.

The issue of financial gain on the part of the doctors and the hospitals with regards to caesarean sections was also mentioned. According to this reasoning, doctors can claim more money for the surgical procedures and for the follow-up visits, as the patient will stay in hospital longer than with a normal delivery. The hospital itself also benefits financially, as the patient who delivers through caesarean section stays in the hospital longer, compared to the one who gives birth through normal vaginal delivery; whilst anaesthetic and theatre time can also be added to the bill, and this is guaranteed to be paid by the medical aid or the individually paying patient.

Management intervention was seen as a method to help in the reduction of the caesarean section rates by engaging with the doctors about the issue as indicated by the following.

P5 ‘...caesarean section: when it’s performed, people claim lots of money (from the medical aid) ... and you stay longer in the hospital, compared to the normal delivery. Which is good ... for the hospital, because the longer they stay, the more ...money come to the hospital. And for the doctors, when they do their claims from medical aids, or maybe from the patients, the money is more than ... for a normal delivery.’

The implication therefore is that ulterior motives are at play in influencing the decisions for and of patients towards a caesarean section, such as convenience and financial gain and with regards to the latter, the hospital might be complicit, since it also gains.

4.3.3 Theme 3: Hospital/institution

Private hospitals have the ideal infrastructure to accommodate patients as they come in for their confinement, or anytime during the nine months for pregnancy-related problems. The hospital employs midwives contractually to take care of the women as private patients of the different doctors that have a working relationship as clients of the hospital. Both private hospitals of Namibia have general practitioners as well as obstetricians admitting patients for confinement.

There are similar policies in both of the private hospital settings regarding indications for admission to the maternity unit, and how some procedures such as an IOL need to be conducted. Doctors work individually or in teams, and most of them also provide standing orders on how their patients must be monitored or admitted when they get to the hospital. The use of the Robson classification as an international guideline to help determine when a caesarean section is indicated is also discussed in the context of the private hospital sector.

4.3.3.1 Policies and guidelines

Policies are there to ensure that actions taken benefit patients in all circumstances. The policies of both hospitals in the study setting concur with the guidelines of WHO (2016) and the Royal College of Midwives (2014) regarding IOLs, which should be done after completion of 41 weeks of pregnancy. However, it also has a clause mentioning that the decision must be made within the doctor's discretion, to provide for emergencies such as pregnancy-induced hypertension. Participants recognised that the policies are present in their work places, but they also mentioned that the guidelines can be interpreted to suit a specific practitioner, and this gives leeway for unaccounted actions.

P4 “there are SOPs (Standard operating procedures), standing orders yes, that state inductions should be done at least after - not before 41 weeks. Some are done earlier, due to (the) patient's own choice, (or the) doctor's choice, or due to medical conditions like PET (Pre-eclampsia toxemia), high blood pressure”

It can thus be argued that policies might be ambiguous and open to manipulation. The participants expressed frustration that this can happen, with the midwife's input being sidelined. The following midwife expressed frustration about the leniency with which existing policies and guidelines are treated, and the lack of more specific standing orders, which should spell out exact actions to be taken in specific instances:

P1 “there are no strict guidelines existing in our setting which guide doctors to make a decision....,”

This midwife explained further:

P1 “There are rules; how to manage patients, when to induce, how to induce, but for instance, not those (that) guide what is an indication for a Caesar. Those rules are not there in Namibia to guide the doctors, so they are left to decide”

It was mentioned that the public hospitals had clearly stated policies and rules specific to how the patient should be managed for the benefit of both the mother and the infant. These policies were enforced, and these are the policies that were taught to student midwives, as part of the midwife’s need to adhere to Namibian legislations. However, when hospitals do not seem to enforce such policies, decision making by the doctors and midwives becomes unregulated. In the face of such a situation, the midwife’s dependent role function then becomes unclear, with possibly dire consequences for the patients, as this ambiguity causes the midwife to become haphazard in the application of legislation (Nursing Act 8 of 2004), with the resultant loss of the independent function or the hazardous application of this function in this process.

P3 “...(it is) very unfortunate that in my current workplace, it’s the patient and the doctor’s say that counts. But if that could change, then, maybe the midwife could also have a say on the decision ...

P3 “...(if) the World Health Organisation’s recommendations on the number of caesarean sections and the reason why the women ... (should have) caesarean sections, would be followed, then maybe the midwife would feel a little bit hands on,”

There is thus a need to involve management, midwives and doctors in finding ways to curb the chances of obstetric staff disagreeing the way a patient must be managed in private hospitals. This problem needs to be addressed for the wellbeing of the patient and to provide a more successful team effort. Midwives are confident that their input is equally valuable in the care of the patient.

P2 “...the managers will just have to sit with the doctors and talk to them nicely because the reasons for caesarean section (is unacceptable) ...It seems now it’s routine to go

for a Caesar – as ‘baby is very big’. How did you see the baby is big without trying the normal delivery?”

P3 “...our management or our immediate supervisor, if we could discuss it with them and then maybe they take it up to say that no, in maternity let the midwife also have fifty-fifty say with the doctor, pertaining to the management and the mode of deliveries that is best for the women.”

When the hospital gives the necessary recognition to the independent role of the midwife, then each role player contributes fully towards the total effort, and responsibility will be shared by all parties involved, with the hospital playing the function of enforcer of legislation and policies.

4.3.3.2 Robson classification

The WHO (2014:2) acknowledges that it is not the actual percentage of caesarean sections that matters, but the reasons behind the procedure - whether they are justifiable for the wellbeing of the mother and baby or not. The Robson classification is an acknowledged tool to provide scientific reasons for doing a caesarean section. However, interviewed midwives had little knowledge of this classification system, with some expressing that even the doctors are not aware of its existence either. Only two participants reported to have some knowledge about it, and they acknowledged that the implementation of this tool can have a positive impact in reducing caesarean sections.

P1 “I do not think anyone is aware of that”

P3 “the classification... No, it does not have any effect (on determining) who goes for Caesarian sections and whom not”

P7 “I have not heard about the Robson Classification”

It is important to note from these observations that the hospitals do not supply information about this system to enforce its use. This indicates a lack of interest in, or a lack of awareness of the large prevalence of caesarian sections in the Namibian private sector.

IOL has positive outcomes for patients having natural births, if done appropriately, and it is one of the ten groupings of the Robson classification. It has positive and negative influences on caesarean section rates, depending on the favourability of the cervix. Participants believed

that this procedure is applied in their workplaces, with some successes, but many failures, which could have been avoided if only done after 41 weeks of gestation. Midwives would like to see these international guidelines regarding IOLs' to be enforced.

P2 “induction of labour - it depends (on) doctors, but basically if a patient is post-dates - she can be induced... it should be 41 (weeks) and above. They can work, it's a fifty-fifty chance. Now it depends what is being used for induction.”

P3 “there are a lot of inductions which are being done and ... according to me ..., (these) are also another contributing factor that would see a patient (having a) caesarean section, because some inductions are just done before there are proper conditions which warrant (it).”

P4 “The ones that are done before, especially if ...the cervix is not ripe, they end up failing, while the others that are done post, after the postdate, there is a chance (to) succeed, more than the one done before the date.”

On attempting to determine which proportion of deliveries are done by caesarian sections, participants mentioned that the number of deliveries varied, depending on whether it is a week day or a weekend, with more being done during the week. Some of the caesarean sections were done as ‘unbooked’ emergencies at the start of the day. However, all seven participants agreed that most of the deliveries in their workplaces were done by caesarean section.

4.3.4 Theme 4: The woman/patient/client

The last theme that emerged as part of the findings was that of the patient/woman in labour. The woman is the focal point for the midwife, doctor and the institution. The focus of the three parties are to strive towards the best interests of the woman and the infant so that the antenatal period, labour and post-partum periods are remembered as cherished experiences, which helps towards the bonding of the newly formed family. The woman must thus be well informed to enable her to make an informed decision based on accurate facts. These information sessions should start at the initiation of the ANC period with her primary caregiver.

The patient in the private sector has a long and trusting relationship with the doctor as the primary caregiver, which is also contractual in nature. Aspects of this contract include antenatal care, informed decision making, and the birth plan as discussed in the following paragraphs.

4.3.4.1 Antenatal care and expectations of pain management in labour

Antenatal care is crucial in obstetrics, as this is when the health care provider and the family meet, and a trusting relationship is formed. This period is also important for the woman to have as much information at her disposal on the birthing options, the pros and cons of each option, inclusive of the coping mechanisms available to deal with pain in labour. Knowledge of the birth process and what level of pain to expect, as well as the methods available to deal with the expected pain, empower women and help them to endure the process to the end. Thus, with increased knowledge, their decisions in labour will be influenced by weighing the negative aspect of pain with the positive aspect of being in control, and following through with their birthing method of choice.

However, midwives reported an observed gap in antenatal care, as most patients did not attend, or were not referred for antenatal classes where they would have received the above information for the necessary choices to be made. It seems that they were only seen by the doctors at the rooms, with inadequate information being provided in the antenatal period about the management of labour.

P1 “the population who has private insurance, for them, midwives are not available, they go to a doctor, and doctors per se, are not trained to take care of women with healthy pregnancies.”

The midwives pointed out that the doctors do not have the time in their rooms to fully inform their patients, as their consulting rooms are usually full of patients who still need their attention, and there might be some interruptions from women in labour that might need sudden and immediate attention. This situation gives rise to a lack of information being imparted and or received, which negatively affects the women’s experience of pain and the whole labour experience, which then might result in the choice of a caesarean section as a mode of delivery to get rid of the discomfort and uncertainty. Pregnancy and labour information are to be explained well so that women can understand these dynamics.

P3 “...the doctor said it’s what is the best, or the doctor said –ah this baby-is still not engaged ...”

P5 “...I don’t know why the doctor is doing a caesarean section on me. He just said I should come to the hospital on this date for caesarean section...”

P1 “...I also feel that mostly women ...(do) not really know what to expect, that it (labour) can take long, and that they might require a second dose of ...medication, I think it depends a great deal how (it is) ... explained...”

A birth plan is the anticipated way that events will take place when a baby is born, and in midwifery, many factors, including fetal distress can prevent the plan from being executed as per the wishes of the woman. Participants mentioned that most women come into the hospital with birth plans already in place as discussed with their doctor. Thus, the mode of delivery would have been decided upon already:

P1 “So once the mum comes to us, she has actually already decided that she wants to deliver spontaneously, but definitely, once they are entering our hospital the decision is already made.”

P2 “Most of them they come already with a birth plan.... like for example, a lot will come with a birth plan for normal delivery, if there is a problem, obviously we are going to change that birth plan.”

P5 “Some come in with their plans, but some are unsure of what type of deliveries (they should have).”

P7 “...most of the woman don’t have a set birth plan, (but) the doctor and the patient has already discussed the birthing method”

However, several midwives expressed their concern that some women believed that they are having a caesarean section due to a big baby and yet on delivery, the infant is of average size, or even smaller than average. The midwives believed that women should therefore be given a chance to try for normal labour, unless there are obstetric indications or complications, for example cephalo-pelvic disproportion (CPD).

P2 “...and you can see if a patient goes for Caesar, they are told the baby is big - coming out at 2,3kg - that’s not a big baby. So, the rate (for this type of event) is too much”

P5 “...and then mostly the reason that you hear from many patients would be – no the doctor said the baby is too big [laugh] sorry, the baby is too big - I can’t deliver by myself and ... it’s better for me to go for caesarean section.”

Pain relief available during labour is a deciding factor regarding birth options. The issue of pain as a determinant of decision-making in the labour wards however, elicited mixed views, as pain is to be expected, is relative and subjective as people's thresholds differ. If pain is dealt with adequately and in a caring manner, it should not be a reason why women decide to change their mode of delivery in the labour wards. The interviewees believed that any pregnant woman should already have anticipated the experience of labour pain in the months leading up to the birth, and have considered how they would cope with it.

P1 ".... so definitely a woman would feel like, ok, they (nursing staff) are doing something to address that issue (of pain), and (the woman) will be willing to continue (with the labour process). I don't think that the pain is the major... point why women decide to have a Caesar."

P7 "So, as soon as you start soothing them and giving them methods on how to relieve the pain, (they are) also a bit more relaxed in going through the process of labour."

However, it seems to many midwives that some women do not anticipate labour pain at all and they are caught unawares and thus they feel that they cannot continue with the process. This is a further reflection on inadequate antenatal care and information at point of entry in the system. Women believe that having a caesarean section will take the pain away immediately – as a 'quick fix' to their agony and despair if they have been in labour for long.

P7 "...it's like they want to get rid of the pain..."

P3 "...I cannot tolerate this anymore..."

One midwife raised the suggestion that patients should be able to meet with midwives at least once or twice during ANC at the hospital, also for receiving information from midwives and fellow women with regards to childbirth. Ultimately, the doctors, who are mostly male, cannot speak of personal experiences of the labour process. Such input from midwives during the antenatal period could help towards a team approach in the care of the patient.

P6 "...women to have may be 1 or 2 contact sessions with the midwives- before delivery, - so that they at least have information- (for) a midwife just to reinforce."

When women have knowledge and access to all the possible and different pain relief methods, this usually motivates them to continue with the labour and normal delivery. Access to

epidurals is a way of ensuring that women are relatively pain free during the process of labour. However, it seems from participants' reactions that this is not a preferred method applied by doctors, due to a lack of time. A doctor needs to be free to do it effectively and timely, and the medication needs to wear off at some point, to help the woman to push effectively during the second stage of labour. It was also verbalised that in some settings epidurals are seldom used, or they are not available at all.

P1 "...they feel they don't have enough options to cope with the pain because the epidurals is not available in our setting."

P4 "but at the end of the day, the ... disadvantage that I have seen, sometimes they can't push, (because with the) ... epidural, ... the sensation in their legs ... is not really that good when it comes to pushing."

Another method of pain relief includes pethidine, which is an opiate. However, midwives verbalised that in their experience, this method only relaxed patients, but it do not remove pain, which then causes some women to rather opt for a caesarean section. This once again indicates a lack of information from the health care providers to the patients on how the medication works when in labour. Apart from this, most of the midwives verbalised that they did not prefer the use these medications as they had too many side effects, especially the sedative effect on the infant when given too close to birth, with poor Apgars resulting, and possible respiratory depression presenting in some infants (National Health System, 2017:1):

P1 "... we have available Pethidine and ...Phenergan as mode of analgesia, which I personally don't like a lot because I think it doesn't work against pain, it (just) makes you feel you don't care about the pain, and has lots of side effects..."

Natural methods to pain control were preferred by midwives, and they encouraged these methods' use amongst women in labour. These methods also give the woman a sense of the midwife's personal touch, and conveyed a feeling of care and concern by the midwife, and sensitivity to the situation. Offering back rubs to the woman helps to motivate her to continue, and this task should also be taught to the birth partner if present, in the process towards encouragement and bonding. Furthermore, warm baths can also be offered, as these help to relax and ease the pain.

P2 “...and when contractions come, the pain will always come. So, the natural ways are better because if the patient is in water will be relaxed ...”

Just being present and encouraging them through the pain can help to yield positive outcomes. This accentuated the importance of a trusting relationship in the expressive function of the midwife in these settings.

4.3.4.2 Support present/ Birthing partner

The goal of most woman on learning about their pregnancies is to have a healthy pregnancy with the anticipation of the arrival of the new family member as a pleasant day to remember. The importance of competent and emotionally supportive people present during the birth should be a priority. When women are motivated and accompanied by a soothing birth attendant, they are well equipped to deal with the pain, instead of finding it unbearable and opting for a caesarean section (Shlegeris, 2017:2).

The midwives expressed harmonious views on the effect of the women having someone with them in the labour ward to offer support. However, midwives often have several patients to attend to, and they find it difficult to be present for a single patient continuously. The midwives also pointed out that birth attendants during the labour can either be motivating towards the end goal of a normal delivery, or to feel sorry for the woman because of pain and this can influence their decision for or against a caesarean section.

P1 “but if they feel they are left alone to deal with their pain and no one is around to assist them, I think that is (when) women are saying, I can’t anymore, take me for Caesar.”

P4 “The midwife and the doctor, and even the relative or the husband who is there - if he is encouraging, like, ‘just continue baby’. It just motivates the mother to push through.”

P7 “(when) she feels there is someone that is going through (the process with) her, (it) might make her also a bit more calmer and relaxed, not scared, but kind of help with pain management.

Women in labour need support, and when there are people around them, they have the experience that they are being supported, with fathers also being encouraged to take part in the birth of their children, as part of the family bonding process.

4.4 SUMMARY

This chapter presented the findings of the research. The work experience and demography of the research participants were presented together with the four themes that emanated from the interviews carried out with the midwives.

The midwives in Namibia expressed different yet harmonised views about the issues around decisions made in the private sector labour wards. Midwives would like to play a more instrumental role via imparting information regarding choices in the labour ward. Such a role would include less focus on surgical interventions, and more on encouraging natural processes, such as availing women with a ‘trail of scar’ period in labour to determine if they would not be able to deliver normally. Furthermore, it would also include the emotional support of the woman to manage the pain, rather than the ‘quick fix’ of a caesarean section. The midwives expressed their need to be involved overall in the antenatal period to imprint healthy options to deal with pregnancy and labour, as doctors do not seem to focus on these important issues in their practice.

Although some doctors were found to be willing to take suggestions and input from the midwives, and some respecting midwives for their valued assessments of the situations, this is not the general experience, but that of a special relationship and reputation built up over a period. However, midwives would like to have their independent role function re-negotiated in the private sector, to align more with that in the public sector.

4.5 CONCLUSION

The major role players in this study were presented in this chapter through the voice of the attending midwife in the labour wards. The midwives expressed that their independent role function in the private sector is not well established, as they are considered to be mere assistants to the doctors. The dependent role function of the midwife in the private sector via workplace policies needs attention, as these policies are often ambiguous, and they are open for various interpretations. Midwives in the private sector understand and acknowledge their interdependent role function, but they expressed the need to be more involved, especially in the antenatal period, in the care of the patients, to enable them to help patients to be more informed regarding their choices in active labour.

The following chapter deals with the key findings in accordance with the study objectives of the views of midwives. Chapter five also contains the study limitations, the appropriate recommendations emanating from the study findings and the conclusion of the overall study.

CHAPTER FIVE:

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The aim of this study was to explore the views of midwives regarding decision making about delivery methods in Namibian private sector labour wards. In this chapter, the conclusions that are based on the findings as presented in chapter four are discussed. The study findings were guided by the reviewed literature. The limitations of the study and the recommendations are included in these discussions.

5.2 DISCUSSION

This is the first study in Namibia to address the views of midwives in the private sector regarding decision making about the mode of delivery. The objectives of the study are discussed individually and related to the data interpretation, to consider how the research objectives were met.

The reviewed literature helped to explain the different roles midwives have in different international settings, from being regarded as independent practitioners working interdependently with the doctors, to settings where the patient and the doctor have a final say on decisions without the input of the midwife. It also established how the surgical intervention is decided on, with the Robson classification system mentioned as an effective tool. Lastly it showed the prevalence of caesarean section as a surgical intervention in labour globally, as well as nationally.

5.2.1 Objective 1: To determine women's decision making on birthing methods in private labour wards

A myriad of factors were raised by the midwives as affecting decisions on mode of delivery in the labour wards. Some of the important factors included anxiety about pain (tokophobia), the significant others or people present during labour (inclusive of the midwife, doctor and family members), the doctor's choice, and poor progress of labour. Decision making pertaining to childbirth is crucial and it involves not only the well-being of the mother but also that of the infant, and ultimately the family. In this context, Swedish fathers mentioned that the mode of delivery does not matter to them, as long as the mother and baby are safe with the option chosen (Johansson et al., 2014:208). However, midwives in this study would like to contribute towards

informed decision making by becoming more involved antenatally to provide information and so improve women's chances of a good outcome in the labour ward.

Women in the labour wards have individual preferences and influences when deciding their birthing methods and this is no exception to the Namibian context. Boz et al., (2016:2) explained that birth partners and relatives should be included in shared decision making, as this allows value based and conscious preferences when it comes to labour and birth. Midwives in this study believe that a birth partner in the labour ward significantly encourages women in labour. The Royal College of Midwives concurs with the above, in stating that the emotional support of the people present, who demonstrate a caring attitude towards the woman, motivates the woman in labour (Ross-Davie, 2012:4).

Tokophobia has been addressed by research (Karlstrom et al., 2011:621, Emmett et al., 2006:1439) as one of the contributing factors to the high caesarean sections as women tend to fear the pain that is associated with childbirth. However, it has been argued that pain is subjective, and the thresholds vary from one person to another and literature concurs that it is an important factor during decision making in the mode of delivery (Nama & Wilcock, 2011:261, Fenwick, Midhons, Gamble, Creedy & Bayes, 2010:395). All the seven midwives that participated in this study mentioned that pain is one of the main contributors of women changing their decisions and asking for a caesarean section at the last moment, since by then their threshold for pain would be very low.

Fear as a factor influences decisions made in the labour wards and this relates to 'fear' of the doctors by the patients when decisions were made, and the patients at times accepting the decisions made by the doctors as the patients are afraid that if they oppose them, the doctors would then not want to take care of them. Midwives in this study supported this notion that some patients do not even know why they are having a caesarean section. This relates to another study which found that the most vulnerable women in society tended to look at experts to tell them what to do without questioning (Vivilaki & Antoniou, 2008:86).

Moreover, according to Fenwick et al. (2010:394), there is a comparatively high likelihood for women to have a caesarean section when they receive private care during ANC and having had limited access to midwives as primary caregivers. This correlated with the present study as the midwives viewed birth as a physiological process which required minimal if any intervention

as opposed to the reported view of the doctors, whom according to the midwives, see pathology even when it is not always the case.

In addition, most of the midwives in this study raised concern over the notion that most caesarean sections are done for the convenience of the doctors as they do not want to be woken up at night or if there is a public holiday and they want no interruptions as they would be travelling. Literature that has been reviewed complements the midwives' views as other studies concur that there are at times some caesarean sections which are performed for the convenience of the doctors (Naidoo & Moodley, 2009: 254, Shahoei et al., 2013:304).

Health education in the ANC period is vital as a time to discuss the pros and cons of a delivery method and the midwives in the private sector expressed the need for the women to possibly have an encounter with midwives before they come to deliver. Literature supports the role of the midwife in the health education of women in the ANC and that women need to be enlightened and thereby be involved in decision making about the mode of delivery (Boz et al., 2016:2, Fenwick et al., 2010:394; ICM, 2014:2).

Therefore, it can be concluded that the midwives in the private sector labour wards in Windhoek concur with the available literature that decisions in the labour wards are influenced by convenience on the part of the doctors, inadequate information given to the women make such decisions, resulting in fear of labour and thus the patients' preference for caesarean sections. From these observations, it can be argued that this objective of the study was addressed.

5.2.2 Objective 2: To understand the use of the Robson classification for caesarean sections in the private sector labour wards

The reviewed literature proffered that the Robson classification, a WHO approved tool to be used to assess, monitor and compare rates of caesarean sections within healthcare facilities should be applied in work places (WHO, 2015:1). It also helps to determine statistically the reasons that lead to the increasing rates of caesarean sections if used consistently. Caesarean sections are essential in the life saving measures of mother and baby when normal delivery is medically contradicted (WHO, 2015:3). The analysis in chapter 4 (section 4.3) concurs with the literature that the caesarean section rates are higher than the normal vaginal delivery in private hospital labour wards. The WHO (2015:2) is concerned about the reasons given for

caesarean sections, and applying this simple, available tool prevents practitioners from carrying out unnecessary caesareans.

The fact that participating midwives had little to no knowledge of the Robson classification meant that the tool was not in use in their private hospitals, which however, can be added under the reasons for a caesarean section appropriately in the maternity register, as taught in their training. Hence accurate statistics cannot be kept regarding this phenomenon that perturbs the WHO and the Namibian government. Studies of countries that have used the Robson classification system indicate reductions in the number of caesarean sections (Abdel-Aleem et al., 2013, Vogel et al., 2015), as they become more aware of appropriate reasons for surgery on pregnant women towards positive outcomes for the mother and baby (Gibbons et al., 2010). The Robson classification has been used to assess its effectiveness in twenty-one countries in the public sector including Brazil, Nepal, Niger, India and Mexico just to mention a few (Vogel et al., 2015). According to the WHO (2015:1), the Robson classification can be adopted internationally to assess and identify barriers for its effectiveness as every effort should be made to provide caesarean section to women in need of the procedure.

Participating midwives expressed their discomfort about policies and guidelines that are present in their work place which are not adhered to, and which are treated with very lenient interpretations. This can be prevented by the use of the Robson classification system via the identification of the groups where most caesarean sections present, and brainstorming being done by the health professionals team to strive to reduce the caesarean section prevalence. The most obvious reason to address, according to the WHO and many scholars, is the prevention of primary caesarean sections and subsequent ones, by using VBAC in the absence of CPD (WHO, 2015:4, Childbirth Connection, 2012:3).

Priority should not be attributed to the achievement of specific caesarean section rates in a setting but a justifiable rate regarding medical indications that are there to save the mother and neonate (Loue et al., 2016:1733). Vogel et al. (2015:261) argue that the increase in the caesarean section rates is driven mostly by caesarean sections that are not medically motivated. The above literature concurs with the views of the midwife who verbalized that some caesarean sections lacked justification on why they are done hence the importance of having the Robson classification being implemented in their settings.

Within the Robson classification there are ten groups which can contribute to a caesarean section, with IOL being one of them. Midwives mentioned their support for IOL done when 41 completed weeks of gestation as this improves the outcome of vaginal deliveries and reduces the risk of unnecessary caesarean sections. This notion is supported by the ICM (2014: 3), WHO (2015:3), and CIMS (2014:3) who have supported IOL only after 41 completed weeks of gestation. Some midwives put across the performance of VBAC in their hospitals which is plausible as it is a way of curbing the caesarean section rates as it gives the women a chance to be able to give birth vaginally after a caesarean section. The application of the Robson classification globally can help in making comparisons among countries, regions and even comparisons within different obstetric management policies (Abdel-Aleem, 2013:119).

5.2.3 Objective 3: To determine the role of midwives as advocates during the women's decision making on mode of delivery

According to the ICM (2014:1), the approach of midwives to childbirth as natural in low risk pregnancies helps to optimize the experiences of women during childbirth, thereby helping them to prepare for motherhood. This study findings reported on similar views of midwives who believed that women should be given a chance to have their babies vaginally unless there are medical complications involved that warrant a caesarean section.

Studies in other contexts such as Greece, assessed the differences in the models of care between midwives and obstetricians and found that midwives would rather choose a vaginal birth than a caesarean section (Vivilaki & Antoniou, 2008:83). Participating midwives in the present study similarly strongly believed that some of the women who went for caesarean sections in the present study settings could have been given a chance to deliver through vaginal delivery.

Kennedy et al. (2010:18) proffers that the UK midwifery model of care 2020 has the view that midwives are the experts in normal pregnancy, but that the context in which midwifery is practiced has since changed over the years. The concern of the midwives in the present study echoes the findings in literature that the training they received and their hands-on experience are lost, as most of the decisions are done by the doctors. However, with increased choices of the pregnant family, Johansson et al. (2014:208) affirm that from the significant other's point of view, the safety of the mother and infant is the most important aspect to consider in decision making. The above information helps the midwife to assert herself as an advocate for ensuring enough pregnancy, labour and mode of delivery information is given to the prospective patients regarding the benefits and indications for each type of delivery.

In conclusion, the midwife should ideally be an advocate in low risk pregnancies. For her to do this, she needs to be able to reach women earlier during their ANC. However, factors such as their diminished scope of practice and their independent roles function currently hinder them from acting out this important role.

5.3 LIMITATIONS OF THE STUDY

The limitation of this study was that only midwives from private hospitals in Windhoek, Namibia were involved, excluding those outside of Windhoek and also the midwives employed in state facilities. Midwives in the third private hospital in Windhoek were excluded as it had less than one year of operating maternity care when the study was conducted. The phenomenon could possibly have yielded more information and understood in more depth if a larger population had commented on the total status quo of decision making in the labour ward. A small sample size was the result of time constraints and the unavailability of more participants, as most of the potential participants expressed that they were not comfortable with the research topic.

5.4 CONCLUSIONS

The study sought to understand the views of midwives on how decisions are made in the private labour wards in Windhoek, Namibia. The key findings based on the objectives were discussed in the form of the decreased role of the midwife and the increased role of the doctor, the role of the private hospital in applying policies, and the role of the private patient in decision making in the Namibian private sector labour wards. Maswime and Masukume (2017) confirm that there is a plethora of reasons that can hinder efforts towards decreasing caesarean section rates in any country, with shortages of midwives, proper use of qualified staff and limited access for patients to information as the three major ones identified in the study.

The willingness of the midwives to express their views with regards to their role in the decision-making process resulted in a clearer picture of their role function in the labour wards of private hospitals in Namibia. Advocacy for women in labour was identified as important for encouraging normal deliveries. Labour support for the patient helps towards dealing with pain emotionally and to cope with this pain until delivery of the baby.

Explorative research was used in this study to understand views of midwives with regards to decision making in Namibia and the midwives were forthcoming in their responses. The midwives expressed the need for becoming more involved team players in the decision making

in their workplaces especially in low risk pregnancies. The positive feedback and participation of midwives is encouraging and gives positive awareness in the Namibian context regarding decision making in the labour wards.

5.5 RECOMMENDATIONS

Recommendations based on the findings of the study are as follows:

5.5.1 Recommendation 1

Midwives should be more assertive in their scope of practice when attending to women before, during and after labour, to be able to know how to advocate for the women during decision making. In addition, midwives need to identify and assert themselves in their independent role function in a diverse and multidisciplinary team. Active involvement and leadership in midwifery organisations like the Independent Midwives Association of Namibia (IMANA) as they are now recognized by the MoHSS should be encouraged, and the IMANA should negotiate for a voice in hospital management towards improved communication and care for their private patients. The IMANA is a part of the ICM.

5.5.2 Recommendation 2

There is a need for more in-house trainings to be done on new protocols from the WHO and legislation from the government, so that management can develop policies that follow from these legislation and protocols, inclusive of the Robson classification system for determining mode of delivery. The trainings should include both midwives and doctors for harmony in patient management. Teamwork should be encouraged amongst the two important care givers and role players in the labour ward, with respect for each other's knowledge and expertise. Decisions from the doctor should be made more transparent to ensure that valid reasons for mode of delivery are entered in the maternity register. Private hospital management should keep a record of these aspects, and commit to provide statistics regarding findings of the use of the Robson classification system, to ensure quality and cost-effective care to their patients. Mahatma Ghandi (Toporek, 2012:1) once said that the client is our reason for being employed, without our client, private hospitals would not exist. Hence evidence-based care (such as the Robson classification system) needs to be applied as a matter of urgency.

5.5.3 Recommendation 3

The midwives in Namibia have a mandate to negotiate with the MoHSS and the private hospitals to encourage and advocate for midwifery led units through the Independent Midwives

Association of Namibia, that will also help patients to have contact with midwives from the planning of pregnancy to the post-natal period, inclusive of the six weeks after birth to have midwives follow up and check on the wellbeing of the mother and baby. Referral networks and birthing privileges to be available to all women.

5.5.4 Future research

The following areas for future research are proposed:

- A nationwide research is necessary including all the midwives in the private sector maternity wards in the different regions, as their views may be different or in agreement with the views of midwives who participated in this study,
- A study in the public sector is also recommended to determine the differences and similarities in the views of midwives and how this can help in forging the way forward in curbing the factors that affect the caesarean section rates, and
- The interdisciplinary relationship between doctors and midwives as health care professionals in the care of the women before, during and after delivery needs to be encouraged, to ensure that the patient remains at the core of their service delivery.

5.6 DISSEMINATION

The research will be disseminated through the university e-thesis hub. Copies of the completed thesis will be also be given to the participating hospitals and the Ministry of Health and Social Services of Namibia.

5.7 CONCLUSION

Chapter 5 discussed the research findings in line with the objectives of the study. Answers to the research objectives were articulated in the findings. Decision making is a pivotal component in childbirth as it determines the outcome in terms of mode of delivery. Midwives are an integral part of obstetrics and their participation and involvement in the active care of women with low risk pregnancies in the private sector, will contribute greatly to the outcome of pregnancy. Women attend ANC with health professionals to receive information about childbirth to make informed decisions so midwives and doctors need to work together to attain this goal. It is the mandate of health care professionals to give all the information including advantages and disadvantages of mode of delivery so that women can make informed decisions that are scientifically based.

REFERENCES

- Abdel-Aleem, H., Shaaban, O. M., Hassanin, A. I. & Ibraheem, A. A. 2013. Analysis of caesarean delivery at Assiut University Hospital using the ten-group classification system. *International Journal of Gynecology and Obstetrics*. 123:119-123.
- Africa Progress Panel. 2010. Maternal health. Investing in the lifetime of healthy societies and economies. Policy brief 2010. www.africaprogresspanel.org [Accessed on 15 August 2017].
- Appropriate technology for birth. 1985. *Lancet*. ii:436-7.
- Banos, N., Migliorelli, F., Posadas, E., Ferreri, J. & Palacio, M. 2015. Definition of failed induction of labour and its predictive factors: two unsolved issues of an everyday clinical situation. *Fetal Diagnosis and Therapy*. 38: 161-169.
- Bergstrom, S. & Goodburn, E. The role of traditional birth attendants in the reduction of maternal mortality. www.citeseerx.ist.psu.edu [Accessed on 12 August 2017].
- Beukes, J. 2015. Quality healthcare remains pipe dream. The Namibian Sun Newspaper, 16 July 2015.
- Boz, I., Teskereci, G. & Akman, G. 2016. How did you choose a mode of birth? Experiences on nulliparous women from Turkey. *Women and Birth*. 507:1-9.
- Brockmeyer, B. 2012. *The health system in Namibia – Deliberations about an affordable national health insurance for the low-income workforce in Namibia*. www.cms.my.na [Accessed on 25 July 2017].
- Booyens, S. W., Jooste, K. & Sibiya, N. 2015. *Introduction to health services management*. Claremont. Juta.
- Butts, J.B. & Rich, K. L. 2008. *Nursing ethics across the curriculum and into practice*. Sudbury: Jones and Bartlett Publishers.

- Chalmers, B., Kaczorowski, J., Darling, E., Heaman, M., Fell, D. B., O'Brien, B. & Lee, L. 2010. Caesarean and vaginal birth in Canadian women: A comparison of experiences. *Birth*. 37:44-49.
- Chen, M. M. & Hancock, H. 2012. Women's knowledge of options for birth after Caesarean Section. *Women and Birth*. 25:19-26.
- Childbirth Connection. 2014. *New cesarean prevention recommendations from obstetric leaders: What pregnant women need to know*. Washington. National Partnership for Women & Families.
- Childbirth Connection. 2012. *Vaginal or Cesarean Birth: What is at stake for women and babies?* New York. Childbirth Connection.
- Chong, C., Su, L. L. & Biswas, A. 2012. Changing trends of caesarean section births by the Robson Ten Group Classification in a tertiary teaching hospital. *Acta Obstetrica et Gynecologica Scandinavica*. 91:1422-1427.
- Coalition for Improving Maternity Services (CIMS). 2010. The Risks of Cesarean Section. www.motherfriendly.org Accessed on 21 July 2015.
- Creswell, J. W. 2009. *Research Design. Qualitative, quantitative and mixed methods approaches*. 3rd ed. London, SAGE.
- Creswell, J. W. 2014. *Research design: Qualitative, quantitative and mixed methods approaches*. 4th ed. Los Angeles: SAGE.
- Cronie, D., Rijnders, M. & Buitendijk, S. 2012. Diversity in the Scope and Practice of Hospital-Based Midwives in the Netherlands. *Journal of Midwifery & Women's Health*. 57:469-475.
- Cronje, A.H. & Grobler, C. J. F. 2003. *Obstetrics in Southern Africa*. Pretoria: Van Schaik.
- Dechenery, A. H., Nathan, L., Goodwin, T. M., & Lanfer, N. 2007. *Current Diagnosis and Treatment: Obstetrics and Gynecology*. New York: McGraw-Hill Companies.
- De Vos, A. S., Strydom, H., Fouche, C. B. & Delport, C. S. L. 2011. *Research at grassroots for the social sciences and the human services professions*. Pretoria: Van Schaik.

- Elo, S., Kaariainen, M., Kanste, O., Polkki, T., Utriainen, K. & Kyngas, H. 2014. Qualitative content analysis: a focus on trustworthiness. *SAGE*. 1-10.
- Emmett, C. L., Shaw, A. R., Montgomery, A. A. & Murphy, D. J. 2006. Women's experience of decision making about mode of delivery after a previous caesarean section: the role of health professionals and information about health risks. *International Journal of Obstetrics and Gynaecology*. 113(12):1438-1445.
- Farine, D. & Shepherd, D. 2012. Classifications of caesarean sections in Canada: the modified Robson criteria. *Journal of Obstetrics and Gynecologists Canada*. 10:976-979.
- Fenwick, J., Midhons, L. S., Creedy, D. K., Gamble, J. & Bayes, S. 2010. Why do women request caesarean section in a normal, healthy first pregnancy. *Midwifery*: 26:394-400.
- Fugleness, D., Aas, E., Botten, G., Oian, P. & Kristiansen, I. S. 2011. Why do some pregnant women prefer caesarean? The influence of parity, delivery experiences and fear. *American Journal of Obstetrics and Gynaecology*. 205:45. 49.
- Gallagher, F., Bell, L., Waddell, G., Benoit, A. & Cote, N. 2012. Requesting Cesareans without Medical Indications: An Option Being Considered by Young Canadian Women. *Birth* 39(1):39-47
- Gibbons, L., Belizan, J. M., Lauer, J. A., Betran, A. P., Merialdi, M. & Althabe, F. 2010. *The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Seactions Performed per Year: Overuse as a Barrier to Universal Coverage*. World Health Report. Geneva: WHO Publishers.
- Given, L. M. (ed.). 2008. *The SAGE encyclopedia of qualitative research methods*. Los Angeles, Carlifonia: SAGE.
- Grove, S. K., Burns, N. & Gray, J. R. 2013. *The Practice of Nursing Research: Appraisal, Synthesis and Generation of Evidence*. St Louise: Saunders.
- Gunnervik, C., Josefsson, A., Sydsjo, A. & Sydsjo, G. 2010. Attitudes towards mode of birth among Swedish midwives. *Midwifery* 26:38-44.
- Hoxha, I., Syrogiannouli, L., Luta, X., Tal, K., Goodman, D. C., Da Costa, B. R. & Juni, P. 2016. Caesarean sections and for profit status of hospitals: systematic review and meta-

analysis. *British Medical Journal*. www.bmjopen.bmj.com [Accessed on 17 August 2017].

International Confederation of Midwives. 2014. Midwifery care for women with complications of childbirth. *International Confederation of Midwives*. www.internationalmidwives.org [Accessed on 21 July 2016].

International Confederation of Midwives. 2017. Appropriate maternity services for normal pregnancy, childbirth and the post natal period. *International Confederation of Midwives*. www.internationalmidwives.org [Accessed on 12 February 2018]

International Confederation of midwives. 2018. Advocacy toolkit. www.internationalmidwives.org [Accessed on 13 February 2018].

International Federation of Gynecology and Obstetrics (FIGO). 2014. Mother-baby friendly birthing facilities. *International Journal of Gynecology and Obstetrics*. 128:95-99.

James, S., Wibbelink, M. & Muthige, N. 2012. Delivery method choice in the South African private sector. *British Journal of Midwifery*. 20:404-408.

Johansson, M., Hildingsson, I. & Fenwick, J. 2014. As long as they are safe – Birth mode does not matter’ Swedish fathers’ experience of decision-making around caesarean section. *Women and Birth*. 27:208-213

Joubert, G. & Ehrlich, R. 2007. *Epidemiology: A Research Manual for South Africa*. 2nd ed. Cape Town: Oxford University Press Southern Africa.

Kaimal, A. J. & Kuppermann, M. 2016. Decision making for primary caesarean section delivery: The role of the patient and provider preferences. *Seminars in perinatology*. 36: 384-389.

Karlstrom, A., Nystedt, A., Johansson, M. & Hildingsson, I. 2011. Behind the myth – few women prefer caesarean section in the absence of medical or obstetrical factors. *Midwifery*. 27:620-627

Kennedy, R., Beasley, D. C., Bradley, M. & Moore, R. 2010. Midwifery 2020 Delivering expectations. www.gov.uk [Accessed on 13 May 2016].

- Keles, E., Gebesce, A., Yazgan, H., Tonbul, A. & Basturk, B. Transient tachypnea of the newborn may be the first presentation of atopic march. *The Open Access Journal of Science and Technology*. 3(2015):1-5.
- Khazan, O. 2014. Why most Brazilian women get C-Sections. The Atlantic Newspaper. 14 April 2014.
- Lampman, C & Phelps, A. 1997. College students' knowledge and attitudes about caesarean birth. *Birth*. 24(3):159-164.
- Lavender, T., Hofmeyr, G. J., Neilson, J. P., Kingdon, C. & Gyte, G. M.L. 2012. Caesarean section for non-medical reasons at term (Review). *The Cochrane Collaboration*. 3:1-16.
- Lincoln, Y. S. & Guba, E. G. 1985. *Naturalistic Inquiry*. Newbury. CA: Sage Publications
- Loue, V. A., Gbary, E. A., Koffi, S. V., Koffi, A. K., Traore, M., Konan, J. K., Effoh, N. D., Abauleth, R. Y., Kouakou, F. & Boni, S. E. 2016. Analysis of caesarean rate and indications of university hospitals in sub – Saharan Africa developing countries using Robson classification system: the case of Cocody's hospital center, Abidjan-Cote d'Ivoire. *International Journal of Reproduction, Contraception, Obstetrics and Gynaecology*. 5(6):1773-1777.
- Mackenzie, S. 2017. "Too much too soon, too little too late". Unpublished paper delivered at the International day of the midwife celebrations. 13 May, Windhoek.
- McLaughlin, K., Van Olst, M. & Whelan, R. 2010. Saving mother's lives in namibia. *Health International*. 10:102-112.
- Magadza, M. 2013. Health for all is possible – health expert. New Era Newspaper 11 November 2013.
- Maree, K. (ed), 2016. *First steps in research*. 2nd ed. Pretoria: Van Schaik Publishers.
- Martin, E. A. (ed.), 2005. *Mini-dictionary for nurses*. 5th ed. New Delhi: Oxford University Press.
- Masson, J. 2010. *Qualitative researching*. 2nd ed. London:SAGE Publications.

- Maswime, S. & Masukume, G. 2017. Increasing caesarean sections in Africa could save more mothers lives. www.wits.ac.za [Accessed on 26 June 2017].
- Ministry of Health and Social Services. 2013. Ministry of Health and Social Services Annual Report 2012/2013. Windhoek: Republic of Namibia.
- Moffat, M.A., Bell, J. S., Porter, M. A., Lawton, S., Hundley, V., Danielian, P. & Bhattacharya, S. 2006. Decision making about mode of delivery among pregnant women who have previously had a caesarean section: a qualitative study. *International Journal of Obstetrics and Gynaecology*. 114:86-93.
- Monari, F., Di Mario, S., Facchinetti, F. & Basevi, V. 2008. Obstetricians' and Midwives' Attitudes toward Caesarean Section. *Birth* 35(2):129- 135.
- Mukherjee, S. N. 2006. Rising caesarean section rate. *The Journal of Obstetrics and Gynecology of India* 56:4. July/August.
- Mylonas, I. & Friese, K. 2015. Indications for and risks of elective caesarean section. *Deutsches Arzteblatt International*. 112: 489-495.
- Naidoo, N. & Moodley, J. 2009. Rising rates of Ceasarean sections: an audit of Caesarean sections in a specialist private practice. *South Africa Family Practice* 51:3.
- Nama, V. & Wilcock, F. 2011. Ethics caesarean section on maternal request: is justification necessary? *The Obstetrician & Gynaecologist* 13:263-269.
- Namibia Medical Aid Fund (NAMAF), 2015. Personal communication (Online), 7 May. Available e-mail: rehettai@namaf.org.na.
- Namibia Statistics Agency, 2016. Region populations. www.citypopulation.de/Namibia.html [Accessed on 28 February 2016].
- National Health System. 2009. *The pregnancy book*: NHS. London: Crown Copyright.
- National Health System. 2017. Pain relief in labour. www.nhs.uk [Accessed on 14 October 2017].
- National Statistics Agency. 2011. Population and Housing Census Indicators. Windhoek: National Statistics Agency.

- Neuman, L. W. 2011. *Social Research Methods*. Boston: Allyn and Bacon.
- Notle, A. G. W. 1998. *A Textbook for Midwives*. Pretoria: Van Schaik.
- Osterman, M. J. K. & Martin, J. A. 2014. Primary caesarean delivery rates, by state/; results from the revised birth certificate, 2006-2012. *National Vital Statistics Reports*. 63:1-10.
- Pera, S & Van Tonder, S. 2011. *Ethics in Healthcare*. 3rd ed. Lansdowne: Juta.
- Polit, D. F. & Beck, C. T. 2012. *Nursing Research: generating and assessing evidence for nursing practice*. Philadelphia: Lippincott.
- Pyykonen, A., Gissler, M., Lokkegaard, E., Bergholt, T., Rasmussen, S. C., Smarason, A., Bjarnadottir, R. I., Masdottir, B. B., Kallen, K., Klungsoyr, K., Albrechtsen, S., Skjeldestad, F. E. & Tapper, A. 2017. Cesarean section trends in the Nordic Countries - a comparative analysis with the Robson classification. 96:607-616.
- Republic of Namibia. 2004. Nursing Act 8 of 2004. Windhoek: Government Printer.
- Ross-Davie, M. 2012. *Evidence Based Guidelines for midwifery led care in labour*. London. The Royal College of Midwives.
- Searle, C., Human, S. and Mogotlane, S. M. 2009. *Professional Practice. A Southern African Nursing Perspective*. 5th ed. Johannesburg: Heinemann Mogotlane
- Sellers, P. 2013. *Seller's Midwifery*. 2nd ed. Cape Town: Juta.
- Shahoei, R., Rezaei, M., Ranaei, F., Khosravy, F. & Zaheri, F. 2013. Kurdish women's preference for mode of birth: A qualitative study. *International journal of nursing practice*. 20:302-309.
- Shenton, A. K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*. 22:63-75.
- Shlegeris, K. 2017. Why partners benefit and are so vital in the birthing process. www.calmbirth.com.au [Accessed on 15 October 2017].
- Smith, S. 2015. Brazil cuts Caesarean craze. *The Namibian*, 9 July:26.

- Snowden, A., Martin, C., Jomeen, J. & Martin, C. H. 2011. Concurrent analysis of choice and control in childbirth. *BMC Pregnancy and Childbirth*. 11:40.
- Tjihenuna, T. 2015. Private hospitals over-perform C-sections. *The Namibian*, 17 July:5.
- Toporek, A. 2012. What is a customer? Did Gandhi really say? *Service Solutions*, 25 October. www.customersthatstick.com [Accessed on 20 November 2017].
- Turner, C. E., Young, J. M., Solomon, M. J., Ludlow, J., Bennes, C. & Phipps, H. 2008. Vaginal delivery compared with elective caesarean section: the views of pregnant women and clinicians. *International Journal of Obstetrics and Gynaecology*. 10:1471-1479.
- Van Dillen, J., Meguid, T., Petrova, V. & Van Roosmalen, J. 2007. Caesarean section in a semi-rural hospital in Northern Namibia. *Bio Medical Central: Pregnancy and Childbirth*. 7(2): 1471-1476.
- Vivilaki, V. & Antoniou, E. 2008. Caesarean section: The underpinning choice? *Health Science Journal*. 2 (2):83-88.
- Vogel, J. P., Betran, A. P., Vindevoghel, N., Souza, J. P., Torloni, M. R., Zhang, J., Tuncalp, O., Mori, R., Moriasaki, N., Ortiz-Panozo, E., Hernandez, B., Perez-Cuevas, R., Qureshi, Z., Gulmezoglu, A. M. & Temmerman, M. 2015. Use of the Robson classification to assess caesarean section trends in 21 countries: a secondary analysis of two WHO multicountry surveys. *Lancet*. 3:260-270.
- Wiegers, T. A. & Hukkelhoven, C. W. P. M. 2010. The role of hospital midwives in the Netherlands. *Bio Medical Central and Childbirth*. 10:80-84.
- Willie, M. M. 2012. Caesarean section rates in large medical schemes in South Africa: An explorative descriptive study. *Journal of Medical Research*. 1(6):084-090.
- World Health Organization (WHO). 2015. Caesarean sections should only be performed when medically necessary. www.who.int/mediacentre/news/releases/2015/caesarean-sections/en [Accessed on 2 April 2016].
- World Health Organisation (WHO). 2015. WHO statement on caesarean section rates. www.who.int/reproductivehealth [Accessed on 2 April 2016].

World Medical Association, 2017. Medical research involving human subjects. www.wma.net
[Accessed on 13 July 2017].

Wu, E., Kaimal, A. J., Houston, K., Yee, L. M., Nakagawa, S. & Kuppermann, M. 2014.
Strength of preference for vaginal birth as a predictor of delivery mode among young
women who attempt a vaginal delivery. *American Journal of Obstetrics &
Gynecology*. 210:440.

APPENDICES

APPENDIX 1: ETHICAL APPROVAL FROM STELLENBOSCH UNIVERSITY



UNIVERSITEIT-STELENBOSCH-UNIVERSITY
jou kennisvennoot • your knowledge partner

Ethics Letter

28-Feb-2017

Mlambo, Sarah S

Ethics Reference #: S16/05/097

Clinical Trial Reference #:

Title: Midwives Views on Delivery method decision making in private sector labour wards of Namibia

Dear Mrs Sarah Mlambo

Your amendment request dated 03 February 2017 refers.

The Health Research Ethics Committee reviewed and approved the amended documentation through an expedited review process.

The following amendment was approved:

1. Collection of data (interviews midwives) at Rhino Park Private Hospital.

Where to submit any documentation

Kindly submit **ONE HARD COPY** to Elvira Rohland, RDSD, Room 5007, Teaching Building, and **ONE ELECTRONIC COPY** to ethics@sun.ac.za

Please remember to use your **protocol number (S16/05/097)** on any documents or correspondence with the HREC concerning your research protocol.

Federal Wide Assurance Number: 00001372

Institutional Review Board (IRB) Number: IRB0005240 for HREC1

Institutional Review Board (IRB) Number: IRB0005239 for HREC2

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Good Clinical Practices Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Sincerely,

Francis Masiye

REC Coordinator

Health Research Ethics Committee 2

APPENDIX 2: PERMISSION OBTAINED FROM MINISTRY OF HEALTH



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2562
Fax: 061 – 222558
E-mail: hnangombe@gmail.com

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3

Enquiries: Ms. H. Nangombe

Date: 03 November 2016

Sarah Mlambo
Master of Nursing Science
University of Stellenbosch
South Africa

Dear Ms. Mlambo

Re: Midwives' views on delivery method decision making in private sector labour wards of Namibia.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for academic purposes;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects' should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
 - 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.5 Preliminary findings to be submitted upon completion of the study;

3.6 Final report to be submitted upon completion of the study;

3.7 Separate permission should be sought from the Ministry of Health and Social Services for the publication of the findings.

Yours sincerely,


Andreas Mwoombola (Dr)
Permanent Secretary



"Health for All"

APPENDIX 3: PERMISSION OBTAINED FROM PARTICIPATING HOSPITALS



Medfam Holdings (Pty) Ltd.

t/a **Rhino Park Private Hospital**

Telephone (061) 375 000 • Fax: (061) 375 001 • Rhino Street • Rhino Park
PO Box 8177 • Rachbrecht • Windhoek • Namibia

01 February 2017

Sr Sarah Mlambo
Maternity Department
Rhino Park Private Hospital
Windhoek
Namibia

Dear Sr Mlambo,

RE: Application for request to conduct interviews with Midwives employed at Rhino Park Private Hospital.

Regarding your application:

After consideration of your proposal, hospital management approved your request with the following conditions –

1. Your study may not have any impact on the Company's or Maternity Ward's operations;
2. Your study may not interfere with any employee's duties or work-schedule;
3. Your results and thesis must be available and submitted to Rhino Park Private Hospital's Management;
4. Preliminary findings must be submitted to Management upon completion of the study;
5. You must supply Management with a monthly report;
6. The data collected must only be used for academic purposes;
7. The data may only be collected by yourself – nobody else may be involved in data collection;
8. No other data may be collected other than those stated in your proposal;
9. All ethical considerations regarding Human Subjects must be adhered to – any violations will result in ending the study;
10. Any violations on any of the above-mentioned points will result in cancellation of the study.

Please note that the only reason Management approved this request, is because you are an employee of this company. Should you leave this Company's employment, this approval will be null and void.

We wish you a successful study.

Yours sincerely,

Esme Botes (B.Pharm)

Director

Directors:

Dr SN Amadhila (MD), Mr CJ Van Niekerk, Dr U Tanneberger, Mrs CM Smith, Ms LE Botes,
Mr W Oosthuizen, Mrs N Heita

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MEDICLINIC OFFICES
STRAND ROAD
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T +27 21 609 6500
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ETHICS LINE 0800 005 316

www.mediclinic.co.za

12 December 2016

Mrs S Mlambo
PO Box 95509
Soweto Market Katutura
Windhoek
Namibia

Dear Sarah

PERMISSION TO CONDUCT RESEARCH AT MEDICLINIC WINDHOEK

Your research proposal entitled "*Midwives' views on delivery method decision making in private sector labour wards of Namibia*" refers.

It is in order for you to conduct your research at Mediclinic Windhoek, and I wish you success with this project.

Yours sincerely


DR ESTELLE COUSTAS
Nursing Executive

MEDICLINIC (PTY) LTD
REG. NO. 1969/009218/07

APPENDIX 4: PARTICIPANT INFORMATION LEAFLET AND DECLARATION OF CONSENT BY PARTICIPANT AND INVESTIGATOR

TITLE OF THE RESEARCH PROJECT: MIDWIVES' VIEWS ON DELIVERY
METHOD DECISION MAKING IN PRIVATE SECTOR LABOUR WARDS OF
NAMIBIA

REFERENCE NUMBER: S16/05/097

PRINCIPAL INVESTIGATOR: SARAH MLAMBO

ADDRESS: P.O. BOX 95509 SOWETO MARKET, KATUTURA, WINDHOEK
NAMIBIA 9000

CONTACT NUMBER: +264814234235

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the investigator any questions about any part of this project so that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research. The study was also approved by the Ministry of Health and Social Services in Namibia as well as the participating hospitals (Rhino Park Private Hospital and Medi-Clinic Windhoek).

PURPOSE OF THE STUDY

The aim of this study is to explore the midwives' views on delivery method decision making in private sector labour wards of Namibia. The research focus is on exploring what the midwives in private hospitals in Windhoek Namibia perceive to be the reasons to explain how women decide in the antenatal active labour phase about a method of birth. The study will also explore whether the Robson classification for doing a caesarean section is followed in their

workplaces and the role of the midwives as advocates during the women's decision making process.

PROCEDURES

If you volunteer to participate in this study, you will be interviewed for approximately half an hour with regards to your views as the midwife. The interview will be audio recorded and no name will be attached to the recording. The interview will take place at your own place of convenience as well as suitable time which you decide upon. The interview will be conducted in English.

REASON WHY YOU HAVE BEEN INVITED TO PARTICIPATE IN THE STUDY

You have been invited to participate in the study because you are a trained midwife who works in a maternity ward at a private hospital in Windhoek Namibia; hence you are positioned to respond to the research aim and objectives of this study.

RESPONSIBILITIES AS A RESEARCH PARTICIPANT

As a research participant your responsibility is to respond to the interview questions in a truthful and honest manner.

POTENTIAL BENEFITS TO RESEARCH PARTICIPANT

As a research participant you will not benefit directly from this research in terms of material gain. The indirect benefit may be (i) an enhanced awareness on the factors surrounding how women make decisions on mode of delivery (ii) a provision of insight in the role of midwives in advocating for women in the decision-making process.

RISKS INVOLVED IN TAKING PART IN THIS RESEARCH

No risks are anticipated in this study although they cannot be ruled out. However, in the event that the research participant feels any discomfort, the research participants will be referred for counseling should any become distressed during the interviews.

PARTICIPATION AND WITHDRAWAL

Taking part in this research is entirely voluntary. You are allowed to withdraw at any time, or not answer some questions but still remain in the study if you so wish.

CONFIDENTIALITY

Any information that is obtained in connection with this study will remain confidential in that no personal information will be divulged in the presentation of data and results. All data will be handled by the investigators and supervisors, and will be anonymized before it is processed, transcribed or analyzed. Confidentiality will be maintained by means of the use of pseudonyms and all data will be in my safe custody under password protected laptop. The data will be used for academic purposes only.

PAYMENT FOR PARTICIPATION

This research is voluntary and as such there will be no remuneration for participating. However your transport and meal costs will be covered for each interview schedule. Thus, there will be no costs involved for you, if you do take part.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Mrs Sarah Mlambo, the researcher on +264814234235, or email sarahmlambo@yahoo.co.uk. You can as well contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study researcher. You will receive a copy of this information and consent form for your own records.

DECLARATION BY PARTICIPANT

By signing below, I agree to take part in a research study entitled: *MIDWIVES' VIEWS ON DELIVERY METHOD DECISION MAKING IN PRIVATE SECTOR LABOUR WARDS OF NAMIBIA*

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 2017.

.....

.....

Signature of participant

Signature of witness

Declaration by investigator

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If a interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) on (*date*) 2017.

.....

.....

Signature of investigator

Signature of witness

APPENDIX 5: INTERVIEW GUIDE

INTERVIEW GUIDE

1. How do women decide on a birthing method when in active labour?
2. How does the Robson classification influence the choice to have a caesarean section?
3. What in your workplace may contribute towards a higher caesarean section rate?
4. How can the midwife be a more effective advocate for women's decision making on birthing methods?

APPENDIX 6: EXTRACT OF TRANSCRIBED INTERVIEW

Transcript 1(P1)

INTERVIEWER: Good morning?

MRS A: Good morning!

INTERVIEWER: Mrs A., how are you?

MRS A: I'm good

INTERVIEWER: Thank you for agreeing to participate in the research and I do hope you read through the participant umm information and you did and you agreed to the...

MRS A: I agree.

INTERVIEWER: Thank you very much. Ok, so as I said earlier I am a student at Stellenbosch and I am doing my masters research. Umm tell more about your experience at the current place of work and what job you do?

MRS A: I'm I'm a midwife in a private hospital, umm working in the antenatal ward where we care for women with pregnancy complications, but also take care of women who are umm in spontaneous labour, or are being induced on the way to deliver normally, umm that is more midwifery work which I like because that is what I do and what I choose to do in my life, umm yah that's so far it.

INTERVIEWER: Ok. So I understand that you are working in a private hospital, you are a midwife. If I could ask, for how long have you been a midwife and ehh how long have you been working at the current work place?

MRS A: I'm working since 2011 in the current place.

INTERVIEWER: Ok. If you can umm point out as to how many deliveries per day, be it caesarean section or normal delivery, that happen in your workplace- in your current workplace?

MRS A: Umm Ok. That's now an estimate neh?

INTERVIEWER: Yes please.

MRS A: We have umm monthly – we have between 120 and 150 deliveries and I would estimate that we have 5 to 6 caesars per day, roughly during work days may be less during the weekends and 2 to 3 normal deliveries per day yah. The latest statistics which if I remember that correctly was that we had like above 60% caesars, and the rest were normal deliveries.

INTERVIEWER: Ok. If I hear you correctly, you have about 60% caesarean sections and 40% or the rest of the percentages to be normal deliveries and you are working in the antenatal department

MRS A: correct

INTERVIEWER: at the present time.

Ok, umm in your experience, how do women umm choose a delivery method when they are in their active umm labour or be it in labour when they come in labour?

MRS A: I think when they are coming to us they have already chosen the way how they deliver. Umm there is... a high percentage of women, I mean the ones which I encounter now at the antenatal side, are those ones who actually opt for having a vaginal birth. So umm we are on umm our ward not dealing with patients who have opted for caesarean umm but definitely once they are entering our hospital the decision is already made. There is umm not much umm influence from the personal side into the choice. So once the mum comes to us, she has actually already decided that she wants to deliver umm spontaneously.

INTERVIEWER: Ok, if I hear you right, all women who come in to the hospital, the antenatal side, in most cases they have chosen the mode of delivery.

MRS A: Yes.

INTERVIEWER: Ok. And are there any changes during labour that influence women to change umm their decision on the mode of delivery?

MRS A: umm of course, there are always influences with which might change umm a decision they have made, like if they encounter umm obstacles they cannot cope with like umm if I may give an example, we have mums who opt for normal delivery but as soon as they reach the point umm of going into active labour when it becomes a bit more difficult to deal with pain, they might change their mind and require a caesarean section, umm but umm we also have those women who are, where I would say that umm, a long umm period of time where they are umm induced and there is no progress, they might also choose to have a umm a caesarean.. but in my opinion, those decisions are mostly guided by the doctor who is taking care of the woman. I think it depends a great deal how women are umm explained and what situation they are and how they are motivated by the people present, umm who are taking care of the mum.

INTERVIEWER: Ok. If I hear you right you mentioned about umm pain as a factor that influences them to change their decision once they got into active labour. And you also talked about induction and umm mostly decisions being influenced by people who are caring for them and also the doctors who also care for these patients.

APPENDIX 7: DECLARATION BY FIELD WORKER

CONFIDENTIALITY AGREEMENT

I Coletta Kandemiri agree to conduct interviews for data collection for Sarah Mlambo who is currently at Stellenbosch University in fulfilment with the Masters programme.

I understand that the information that I will receive and hear will be confidential and will only be shared with Sarah Mlambo.

I agree to using the information only for what it is intended for.

Signature:

ID Number:CN935212

Date:03/03/2017

Researcher: S Mlambo

ID Number:BN704099

Date: 03/03/2017

APPENDIX 8: DECLARATIONS BY LANGUAGE AND TECHNICAL EDITORS

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29 November 2017

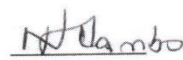
To whom it may concern

LANGUAGE AND TECHNICAL EDITING – MRS SARAH MLAMBO

This letter serves to confirm that a Master of Nursing Science thesis entitled MIDWIVES' VIEWS ON DELIVERY METHOD DECISION MAKING IN PRIVATE SECTOR LABOUR WARDS OF NAMIBIA by Sarah Mlambo was submitted to me for language and technical editing.

The thesis was professionally edited and track changes and suggestions were made in the document, which if followed by Mrs Sarah Mlambo, will result in a thesis with a high standard of English.

Yours faithfully



Dr N. Mlambo

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PhD in English
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M.A. in English
B. A. Special Honours in English – First class
B. A. English & Linguistics



To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the language editing and technical formatting of Sarah Mlambo's thesis.

Technical formatting entails complying with the Stellenbosch University's technical requirements for theses and dissertations, as presented in the Calendar Part 1 – General or where relevant, the requirements of the department.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Lize Vorster', written over a large 'X' mark.

Lize Vorster
Language Practitioner

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